

# Bathing Without a Battle

*Person-Directed Care of Individuals  
With Dementia*

**Second Edition**

## Springer Series on Geriatric Nursing

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*Editors*

  
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*This book is dedicated to all the direct care workers  
who care deeply and struggle daily to provide  
compassionate and skillful individualized care.*

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## Preface

### INTRODUCTION

The purpose of this book is to change current bathing practices that create unnecessary distress and discomfort for persons with dementia. For many persons, bathing remains a pleasant experience. But in some cases, bathing becomes a battle for the care recipient and the caregiver. In the last decade we have learned much about ways to improve care for persons with dementia. We have changed many long held practices and beliefs about what constitutes good care. Yet, many of our standards related to bathing frail elders, particularly those with dementia, remain unchallenged. We hope to change some of your ideas about assisting persons with dementia with bathing by sharing lessons we have learned from many years of clinical practice and 9 years of conducting research in this area.

### THE HISTORY OF OUR APPROACH

The approach to understanding and reducing the distress of bathing persons with dementia presented in this book was developed by two multidisciplinary teams of health care providers and researchers: one at Oregon Health Sciences University (OHSU), the second at the University of North Carolina-Chapel Hill (UNC-CH) and John Umstead Hospital (JUH), Butner, North Carolina. During the course of our studies, we have given over 1,000 baths and have worked with more than 50 nursing assistants.

We began at UNC-CH and JUH in 1992 with a grant funded by the National Institute of Aging (NIA) as part of a jointly sponsored initiative with the National Institute of Nursing Research (NINR). We found that there were some nursing assistants who seemed to be able

to gain the cooperation of patients who were usually aggressive. We watched what they did and talked with them about their approach to care.

From these experiences we learned much about what helps and what makes the bathing experience worse. We had hoped to be able to develop prescriptions for coping with behavioral symptoms such as yelling and hitting, but we found that we needed a person-centered, psychosocial, problem-solving approach. This enabled us to tailor each bath to the individual. We tried this approach in two nursing homes and found that we could make most bathing experiences more pleasant. We also found that a bed bath seemed to be more comfortable than a shower or tub bath for the most severely impaired individuals. Having the flexibility to bathe a person in a number of different ways was crucial. However, we knew that we would have to test our ideas in a more rigorous study before we could convince others that a shower or tub bath wasn't the only way to get a person clean.

At the same time, the OHSU team was funded by NIA as part of the same joint initiative with NINR to conduct a pilot and feasibility study for a clinical trial on changing nursing home staff's approaches to bathing persons with dementia. Our first aim was to gain a better understanding of how much of a problem aggressive behavior was during bathing residents with dementia (e.g., what kinds of behavioral symptoms occurred and how frequently). Our second aim was to determine if a bedside model of consultation between the direct care provider and a clinical nurse specialist, focused on problem solving and individualizing care, would be effective. We found, as did the UNC team, that when we individualized the bath and the bathing care plan we were able to dramatically reduce the aggressive behaviors.

An important insight we gained was that the relationship between the caregiver and care recipient was essential. Nursing assistants who were able to shift from

a task-focused to a person-focused approach were more successful in trying new approaches. Another insight was that nursing assistants valued the support they experienced from the consultant for trying new ideas. They expressed that this was often missing from their coworkers or supervisors. Another important “discovery” was that an in-bed bath, where the person is fully covered with a towel moistened with no-rinse soap and washed and massaged through the towel, often was comforting and soothing for persons who found even a person-directed approach to the shower or tub bath distressing. It was also effective in reducing aggressive behaviors and distress. The nursing assistants who participated also found bathing persons with dementia to be a more positive experience.

Our two teams met because of our mutual interests and decided to join forces in 1995. We believed that our combined approaches from different discipline perspectives (e.g., nursing, medicine, psychology) and the research methods we developed in our first studies would strengthen a larger-scale study across multiple sites. We received funding from the National Institute of Nursing Research to examine two kinds of bathing: a shower and in-room bathing in 15 nursing homes in Oregon and North Carolina. Two of the authors (Joanne Rader, Ann Louise Barrick) worked side by side with the nursing assistants to learn how to increase pleasure and how to decrease distress for the residents included in the study.

Since the completion of our research we have continued to work closely with persons with dementia and their caregivers to increase our knowledge and improve the bathing experience. We have learned that “person-directed” is a better description of our approach. It emphasizes choice and puts the person receiving care first. It also supports caregivers in the provision of care that honors the preferences of the care recipient.

## ABOUT THE BOOK

Out of these experiences we developed the approach to bathing persons with dementia discussed in this book.

Part I explores bathing from an overall perspective. The model that guides our work is described in chapter 1. Chapter 2, the history of bathing, illustrates that bathing practices have changed over the years and that there is more than one way to get someone clean. Chapter 3 includes general techniques that help most persons feel more comfortable during bathing. Chapters 4 and 5 cover assessment and interventions for making your bathing plans person-directed. Both are filled with the many ideas gathered while working with very creative and caring nursing assistants. Part II of the book has been updated and is devoted to special concerns related to bathing such as pain, skin care, determining the appropriate level of assistance, transfers, and the environment. An enhanced Part III addresses ways to support caregivers by increasing their understanding of the care recipient’s needs and their knowledge of interventions to improve care and comfort. It also emphasizes self-care and system-level changes to promote person-directed care. Several chapters include specific insights and wisdom from direct caregivers.

We worked in health care facilities, but many of the ideas in this book also apply to persons being cared for at home and other settings such as day care programs. Also, although we have focused our discussion on persons with dementia, we believe that many of the approaches discussed in this book are equally useful when caring for other frail elders. Finally, we believe our person-directed problem-solving approach and techniques can be useful during other caregiving activities such as morning and evening care.

Our work is not finished. We invite you to use the model and the solutions we found helpful in your own work. Use your creativity to find the best way to bathe each person in your care. There is no right way to bathe a person, but there are many better ways than the current common practices. Bathing can occur without a battle. We hope you will agree.

We hope that one day nursing homes will offer therapeutic water treatments in relaxing environments. Perhaps some will even be included in *Fodor’s Healthy Escapes*. Preposterous? Let’s hope not.

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# PART I

## The Basics

# CHAPTER 1

## Understanding the Battle

*Beverly Hoeffler, Joanne Rader,  
Ann Louise Barrick*

Imagine yourself as an older person living in a nursing facility or at home with a professional or family caregiver. You grew up when personal care was done in private and seldom discussed. Before you became ill, you bathed in a tub in a small warm bathroom that you decorated to your liking many years ago. However, you are having increasing trouble caring for yourself at home because of memory problems, arthritis, and poor balance. Or perhaps, after falling and bruising yourself badly, you were admitted to a nursing home after a short hospital stay. Today you are confused and have difficulty remembering where you are or recognizing the people who come into your room. You ache from arthritis in your joints and experience pain when you move your arms and legs. You are lying in bed, lost in your memories, when suddenly someone tells you it is time for your shower. You can't figure out who this person is, but before you know it you are swung through the air in a lift and plunked down on a cold chair that looks like a rolling toilet seat. You cry out because you hurt, but the stranger doesn't seem to notice. Instead, she says, "This won't take long." Then she strips off your bedclothes, puts a blanket around your shoulders, and pulls you backward down the hall in the chair. You feel exposed as cold air hits your bottom and thighs. You are afraid and feel that you have no control over what is happening. Your eyes show your anxiety, and you call out, "Help me, help me!" repeatedly, louder and louder. The stranger responds, saying, "I'm just taking you to the shower; I'm not going to hurt you," but it doesn't feel that way to you. Then you are in a small room sitting in this toilet seat chair, stripped naked again. The stranger is spraying you with water, asking you, "Is it too hot?" . . . and you cry out, "Too hot, too hot!" And then, "Oh, I'm cold, I'm cold!" Instead of responding to your cries she raises your arm up. This hurts, and you yell, "No, no, no, no, no, no!" and

try to push her away. She tells you she is just washing off the soap, but you feel assaulted and ignored. You don't want a shower; you don't want someone touching you. You . . . just . . . want . . . out . . . of . . . that . . . room and away from the spraying water!

Now, imagine that you are the caregiver trying to help this person take a shower. Bathing is one of the tasks you are assigned, and you want to do a good job. You like taking care of older people, and the last thing you want to do is cause this person pain or distress. But nothing you say or do seems to help. You steel yourself against her cries and complaints of pain and try to ignore them. Afterward, you are upset with the resident for making you feel so incompetent. You no longer look forward to caring for her because it feels like such a battle. You pray that she gets assigned to someone else.

### BEHAVIORAL CHANGES IN DEMENTIA

The scenario you just imagined describes an all-too-frequent experience of older persons with dementia and caregivers assigned to help with their personal care. With some alterations in the scenario, it could represent the experience of family caregivers when persons with dementia no longer recognize familiar faces, as can happen in later stages of the illness.

Dementia is not a disease per se but a general term for disorders in which damage to brain cells results in irreversible cognitive decline. To be called dementia, a disorder must have the following features:

- decline in at least two of four essential areas of cognitive functioning (i.e., memory; ability to generate coherent speech or to understand written

or spoken language; capacity to plan and make sound judgments; ability to process and interpret visual information)

- impairment in daily functioning, that is, difficulty carrying out daily activities such as shopping or bathing.

Specific brain abnormalities are found in different types of dementia. For example, deposits of protein called plaques and twisted strands of protein called tangles are hallmarks of Alzheimer's disease (AD), the most common dementia. Blocked small arteries and reduced blood flow to areas of the brain due to strokes characterize vascular dementia, the second most common type of dementia. The abnormalities in the central nervous system remain invisible to us, revealed only through autopsies and brain imaging using magnetic resonance imaging (MRI) or computerized axial tomography (CAT) scans (Alzheimer's Association, 2007).

What we as caregivers observe—especially as the dementia progresses—are changes in behavior and communication caused by brain disease. From the caregiver's perspective, behavioral symptoms such as physical and verbal aggression or wandering are frequently viewed as “defiant behaviors,” “problematic” or “troublesome” behavior, or “disruptive behaviors.” Often this perspective implies that the person with dementia is the problem or is having a problem that needs to be managed. If we turn the lens around and look at behavioral symptoms from the view of the person receiving care, a much different perspective emerges. Behavioral symptoms become ways of communicating experiences such as:

- fear, pain, or distress
- expressions of unmet or unidentified needs
- self-protective behavior against an invasion of personal space or feeling assaulted.

Ultimately, behavior becomes the primary means of communication for persons with dementia when they can no longer express their feelings, needs, or desires verbally or engage in problem solving with others (Algase et al., 1996; Kovach, Noonan, Schlidt, & Wells, 2005).

As the population ages, dementia is becoming an increasingly significant health problem likely to touch all of our lives in some way. AD affects more than 5 million Americans, 96% of whom are 65 and older (Alzheimer's Association, 2007). The prevalence of AD increases with age and, in fact, doubles every 5 years

beyond age 65 (National Institute of Neurological Disorders and Stroke, 2007). Currently, 13% of persons age 65 and over have AD; however, nearly half of persons age 85 and over have AD (Alzheimer's Association, 2007).

The majority of persons with AD are cared for at home, although many families turn to facilities to provide the 24-hour care required in the later stages of this progressive illness. Approximately 70% of all nursing home residents and more than 50% of persons living in assisted living facilities have documented evidence of cognitive impairment or dementia (Alzheimer's Association, 2007). Declining ability to carry out activities of daily living (ADLs) and increasing occurrence of behavioral symptoms during assistance with personal care are often factors that lead to nursing home placement.

## PREVALENCE OF BEHAVIORAL SYMPTOMS DURING BATHING

We know that behavioral symptoms of dementia that occur when assisting persons with personal care activities such as bathing are among the most troublesome and difficult for caregivers. Family members surveyed in one study reported that 65% of the persons with dementia they had cared for at home had become aggressive during caregiving (Ryden, 1988). In another study, family members reported that as cognitive impairment became more severe the number of persons with behavioral symptoms increased (Teri, Larson, & Reifler, 1988). They also indicated that assisting with hygiene precipitated the most problematic behaviors. Within nursing homes, behavioral symptoms ranged from an average prevalence of 43% among all persons across a number of studies (Beck, Rossby, & Baldwin, 1991; Beck et al., 1998) to 86% of persons with dementia in one study (Ryden, Bossenmaier, & McLachlan, 1991). In the latter study, nearly three-fourths (72.3%) of aggressive behavior among 124 nursing home residents occurred during caregiving activities involving touch or invasion of personal space.

When caregivers are asked about behavioral symptoms that occur during assistance with personal care such as bathing, they describe behaviors that fall into three general categories. These include:

- resistive behaviors (e.g., pulling away to avoid being bathed; trying to leave bathing area)

- vocal agitation or distress (e.g., crying, loud exclamations such as “Oh! Oh!”)
- verbal and physical aggression (e.g., cursing, threatening, hitting, biting, grabbing, pushing).

Study teams in Oregon and North Carolina conducted two surveys to better describe behavioral symptoms that occur during bathing and to better describe the extent to which bathing persons with dementia is difficult for caregivers in nursing facilities. In Oregon, the team collected in-depth data on all residents in one nursing home over a 6-week period (Hoeffler, Rader, McKenzie, Lavelle, & Stewart, 1997). Most residents were bathed weekly in this facility. At the beginning of the survey, 93 of the 102 long-stay residents (91%) required assistance with bathing. Eighty-six of these residents remained in the facility throughout the 6-week period and were included in the study. The nursing assistants who helped residents with bathing completed a checklist of physical, verbal, and sexually aggressive behaviors. The team analyzed data from the first four baths for each resident. Nearly half (41%) were aggressive during at least one of the four baths, and a significant number (16%) were aggressive almost every time (i.e., during three of the four baths). The majority of residents (60%) who were aggressive during one bath had a dementia diagnosis, and an even higher percentage (72%) who were aggressive during almost every bath had a dementia diagnosis. Most of these residents (63%) were both physically and verbally aggressive during bathing while very few were sexually aggressive. By far the most frequent types of physically aggressive behaviors reported by nursing assistants in descending order of frequency were:

- hitting, punching, or slapping
- pinching or squeezing
- pushing or shoving.

Verbally aggressive behaviors reported were fairly evenly distributed among:

- hostile language
- name-calling
- cursing or obscene language.

Aggressive behavior occurred most often during the bath itself but also during undressing and transportation to the bath. The nursing assistants reported other kinds of behaviors not included on the checklist that they found troublesome. These included vocal agitation such as:

- crying
- calling out
- yelling.

The bathing study team in North Carolina took a different approach to learning more about the extent of the problem. The team conducted a survey of 60 nursing homes in North Carolina, drawn randomly from a list of licensed facilities in the state, and of 54 facilities nationwide operated by one proprietary group (Sloane et al., 1995). A questionnaire was mailed to the director of nursing or charge nurse familiar with bathing-related issues in each facility. Seventy-one facilities (62%) completed and returned the questionnaires. Half of these facilities had special care units for persons with Alzheimer’s disease.

More than three-fourths of residents usually received a shower that was almost always given in a common bathing area. Very few received a bed bath in their own room. Only half of the nurses reported that they were satisfied with the bathing process in their facility. On average 20% of the residents were reported to be difficult to bathe. Of the residents who were reported to be difficult to bathe, 81% had a diagnosis of dementia. The kinds of behaviors reported as common among persons with dementia who were difficult to bathe were similar to those reported by the caregivers in the Oregon survey. Behaviors reported at least half of the time included physically and verbally aggressive behaviors, resistive behaviors, and vocal agitation.

We know less about the prevalence of behavioral symptoms when family members assist persons with dementia during bathing. In a national telephone survey, 35% of caregivers caring for persons with dementia at home reported that they helped bathe or shower (Alzheimer’s Association and National Alliance for Caregiving, 2004). One study of 64 family caregivers of persons with dementia found that 41% assisted their family member during bathing. About half of these found it to be “pretty hard” or “somewhat hard” (Archbold et al., 1997).

## WHEN DOES THE BATTLE BEGIN?

We often think of bathing as the time a person spends in the bath or shower. But in caregiving situations, bathing begins with the invitation to the bath. The invitation to the bath is a pivotal time for the battle to start or be

prevented. Bathing-related activities during which the battle can occur or be prevented include:

- undressing and dressing
- transfer between the bed or bathtub and a chair
- transportation to the bath or shower room
- bath or shower procedures, including washing
- drying
- hair washing or shaving.

It is not the activity itself that causes behavioral symptoms but the person's experience of the situation from invitation to completion of the bath. The most frequent antecedents or causes of behavioral symptoms during personal care activities such as bathing reported in the literature include:

- touch or invasion of personal space
- perceived loss of control or choice
- anticipation or experience of pain
- feeling that one's needs and preferences are being ignored
- frustration because of declining self-care abilities
- impaired ability to express or communicate needs or feelings
- impaired ability to recognize caregiver's actions as helpful
- tense caregiver appearance, nonengaged communication, or task-oriented behavior.

Because persons with dementia may no longer recognize the caregiver's actions as helpful, they may feel threatened by the invitation to the bath and perceive the bath as an assault. Resistive and aggressive behaviors can be viewed as a defensive response to a perceived threat (Bridges-Parlet, Knopman, & Thompson, 1994) or as protective behavior (Talerico & Evans, 2000), a way for persons to fight back in an attempt to prevent harm from occurring to them during bathing.

A useful way to think about the battle is to view it as a conflict between the agenda of the caregiver and the agenda of the person with dementia. In an observational study of 33 persons with dementia, Kovach and Meyer-Arnold (1996, 1997) found that 92% became agitated or resistive as soon as they were told it was time for a bath. The high prevalence of behavioral symptoms during the invitation to the bath suggests conflicting agendas *from the beginning* between the person with dementia and the caregiver. The caregiver feels that he must give the bath, and the person with dementia, who does not want the

bath, feels little control over the situation. Both cope with their conflicting agendas through verbal and non-verbal strategies, all of which have meaning within the context of the bathing situation. Persons with dementia cope with loss of control through behaviors that reflect attempts to resign, share or attain control, and/or regain inner control. Behavioral symptoms (resistive behaviors, vocal agitation, and physical and verbal aggression) occur most often during attempts to attain control or to regain inner control.

Kovach and Meyer-Arnold (1996, 1997) also found caregivers' communication styles and actions related to the occurrence of either calm or agitated behavior among the persons being bathed. Engaged communication included:

- conversation with the person about general topics
- attention to the person's need for comfort and personal preferences during bathing
- reassuring, explaining, and comforting phrases
- diversion
- requests for the person's participation
- humor and compliments.

Nonengaged communication included:

- talking to another caregiver rather than the person
- firm directives and coaxing
- degrading comments and jokes at the person's expense
- saying nothing when the person indicates a desire for communication or shows anxiety.

A person-directed approach—paced to meet the needs of the person being bathed—rather than a task-oriented approach that is often rushed to meet the needs of the caregiver, is key to preventing the battle. It serves to calm and to help the person cope more successfully with the situation.

The physical environment can also contribute to behavioral symptoms during bathing. Environmental factors that lead to discomfort and apprehension, often expressed as resistive, agitated, or aggressive behavioral symptoms, include:

- unfamiliar appearance of bathing rooms in facilities
- bathing apparatus and transportation equipment
- air temperature of the room
- spraying and running water

- unexpected fluctuations in the temperature of the running water
- loud or unusual noises.

Consequently, the battle can be precipitated by events in the physical environment that affect the experience of caregivers and persons with dementia.

Moreover, caregivers report that the support they perceive from their coworkers and supervisors, and from the culture in the facility, influences their approach to bathing persons with dementia. Factors that affect this “caregiving tone” include:

- philosophy
- policy and procedures
- staffing patterns
- structure of day
- equipment and supplies.

The importance of these organizational factors on interactive caregiving is critical. These factors control how much flexibility and caregiving creativity the organization will accept and support. Sometimes caregivers are pressured to conform to rigid policies, procedures, and schedules. Other times, the open, facilitative tone set by the administration gets lost or distorted as it travels to those directly interacting with people with dementia.

Some facilities allow only one towel and one washcloth per bath. This makes it difficult to keep the person covered and warm. Other facilities require showers and do not allow bed baths. In homes, there may be rigid beliefs about how to help someone stay clean or beliefs about when baths can or can't be done. Such policies and beliefs can set the stage for a battle.

Thus, interventions aimed at making bath time a more positive and pleasant experience must take into account the organizational and physical environments that help shape the psychosocial or interpersonal environment in which bathing occurs.

## ADDRESSING MYTHS ABOUT BATHING

There are some strongly held beliefs about what is required to keep people clean that need to be addressed. Most of us resist change. It is generally “easier” to do what we have always done. A number of myths about bathing have to be confronted and overcome to champion

change related to bathing. Some common myths to consider are:

### You Have to Use Lots of Water to Get Clean

Many conscientious caregivers worry that they need to use lots of water in the shower, bath, or bed. However, people maintain cleanliness without the benefit of showers, tubs, or running water at home and in other settings. Washing with attention to detail is more important than how much water you use.

### If Caregivers Are Delaying, Deferring, Shortening, or Adapting the Bath or Shower, They Are Trying to Get Out of Work

This is not about being lazy. It may be necessary to create a person-directed plan that meets the person's special needs. Caregivers are still responsible for maintaining the person's hygiene, but they need freedom to adjust the method. Altering the bathing method or schedule actually may reflect the caregiver's commitment to good care and conscientiousness rather than suggest the caregiver is trying to get out of work.

### Families Will Insist on a Shower or Tub Bath

Families, like the rest of us, need to be educated. Once presented with the problem (e.g., the person dislikes or fights the bath or shower) and alternative suggestions, families usually understand and agree to try other methods.

### There Will Be More Infections and Skin Problems if You Don't Use a Lot of Soap and Water

In our culture, especially during the 20th century, we associated the importance of bathing with the prevention of health problems. However, our experience suggests and data show that modifying the bathing experience and using methods other than the routine bath or shower and plenty of regular soap do not result in more skin problems or infections. A no-rinse soap solution may prevent allergic reactions to soap products and skin problems such as drying.

### People Always Feel Better After a Bath or Shower

Just because we feel better after a bath or shower does not mean others do, particularly when it is uncomfortable

or they clearly state they don't want it and it is forced upon them. In these cases the person feels distressed or violated.

#### You Have to Just Go Ahead Because for Most People Who Resist, There Won't Be a "Good" Time

For most people with dementia, developing a plan that keeps them clean and avoids the battle is possible. When the approach, method, day, and time of day are adjusted to the person's needs, bathing without a battle is almost always the outcome.

#### They Just Forget About the Battle so It Doesn't Matter

Many people who are forced to bathe stay upset for hours following the task. It is almost as if our care plans say, "agitate to the point of aggression one to two times a week during bathing." If the person feels she is being forced or threatened on a regular basis during bathing, our experience suggests that even with memory loss there can be a lasting effect on the person's overall feelings of safety and well-being. Examples of lasting outcomes from forced bathing could include refusal to take medicines, aggressive confrontations with other residents, or further resistance with staff in other care areas.

#### Regulators, Advocates, and Families Will See It as Possible Neglect

The risk of being misjudged is greater if the only message given is what is not being done, rather than the more positive message of providing person-directed care. The goal is to provide good care by meeting the unique needs of persons with dementia and by avoiding distressing bathing situations. Plans for evaluating problems and for monitoring improvement also need to be presented.

#### A Person-Directed Approach Will Take More Time, and We Don't Have Time for Extra Care

For most persons, person-directed care can be done in the same amount of time as routine care once you are familiar with new methods, approaches, and techniques. There may be a decrease in overall time spent bathing if you end up bathing some people less frequently.

## THE IMPACT OF THE BATTLE

What happens if the battle is not prevented or lessened in some way? What are the consequences for persons with dementia and caregivers? If you have experienced the battle yourself or if you have observed its occurrence at home or in a nursing facility, then the consequences may sound familiar. After experiencing the battle during bathing, persons with dementia may remain upset and agitated throughout the day, which affects their relationships with others with whom they have daily contact. The result is that they may become increasingly isolated and depressed, and others may avoid them. Often they become perceived as difficult and troublesome. Too often the outcome has been the use of physical restraints or the misuse of psychoactive medications to control behavioral symptoms (Talerico & Evans, 2000). We usually think of physical restraints as tying someone down, but other forms of restraint include using several caregivers to hold a person against his will while the bath is given quickly.

Behavioral symptoms, especially aggressive behavior, have serious consequences for caregivers in community and nursing home settings. Caregivers in nursing facilities rate assisting persons with dementia during bathing or showering one of the hardest, if not the hardest, caregiving task that they perform (Miller, 1997; Namazi & Johnson, 1996). Caregivers experience distress and frustration with the caregiving role and may become depressed about their situation. Ultimately, this leads to caregiver burnout and a sense that the burden of caregiving is too great. For family caregivers, the result may be that they can no longer provide the care at home. In nursing facilities, the outcomes are often low staff morale and high staff turnover. Such outcomes are reflected in the findings of a qualitative study conducted in a Dementia Special Care Unit (Miller, 1997). Thirty nursing staff members were interviewed to explore the effects of physically aggressive behavior during hygienic care on them personally and on their practice. Staff reported declines in their physical health, such as pain and exhaustion, and in their mental health. Mental health concerns were:

- concern about their safety during caregiving
- mental exhaustion, frustration, anger, sadness, depression, and anxiety
- fear of being perceived as a poor worker by their peers or administration.

The staff's daily experiences with aggressive behavior during caregiving also resulted in changes in their practice, such as:

- decline in the perceived quality of nursing care
- increase in the potential for staff-to-patient abuse and neglect
- desire to eventually leave the unit, the facility, or the profession.

Findings for this qualitative study are consistent with results from surveys and from anecdotal reports of caregivers' experiences found in the literature.

## CONCLUSIONS

For persons with dementia who no longer feel in control of their lives and who are avoided by others, for caregivers who feel burdened and distressed by the experience, and for facilities faced with constant turnover, the costs of the battle are high. The answer lies in challenging the myths and changing the experience for all involved by finding new ways that bathing can occur without a battle.

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