Family Conflict in the Nursing Home Setting

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Overview

- Defining terms.
- Rationale for understanding family conflict.
- A research agenda on the causes and consequences.
- Implications for “best practices”
- Case study in the nursing home setting

What is Family?

- “People in a committed relationship from which they shape a sense of identity”

(Kissane & Bloch, 2002, p. 2)

- Whoever its members say it is

(Kissane & Bloch, 2002, p. 40)
What is family conflict?

“Interpersonal tension or struggle among two or more persons (within the family) whose opinions, values, needs or expectations are opposing or incompatible.”

(Kramer et al., 2006, p. 794)

Why is Family Conflict Important to Understand?

Clinical guidelines mandate

Families intimately involved in:

• Care planning
• Decision making
  • When conflict present, proxy decision makers less likely to make decisions consistent with elder’s wishes.
  (Parkes et al., 2011)

Impact of Illness on Family Functioning

• Communication problems increase as illnesses progress
  (Zhang & Siminoff, 2003)
• Illness severity predicts higher levels of family strain
  (Takes, Schult & Biege, 1992)

Conflict Common & Matters

• At end of life -
  − 35% - 57%
  (Boelk & Kramer, 2012; Kramer et al., 2006, 2010b).
• “What matters most in EOL”
  − Unresolved issues/conflicts
  − In top 4 (out of 28) of importance among seriously ill patients
  (Heyland et al. 2006)

Conflict Exacerbates Suffering

• Of Patient
  − 95% of Bio-ethics consults = conflict
  (Steinoff-Blair, 2006)
  − Longer tx side-effects
  (Kim & Marino, 2006)
  − Aggressive tx - nursing home
  (Joyce, 2009)
Conflict Exacerbates Suffering

• Of Family Members
  – CG burden & depression
    (Heru & Haas, 2006; Strawbridge & Wallhagen, 1991)
  – Complicated grief
    (Heru et al., 1996b; Kissane et al., 2006)

Professionals Struggle

• Report feeling:
  – Ill prepared to address conflict
    (Back & Arnold 2005; King & Quill 2006)
  – Less successful addressing care needs when conflict present
    (Kisner & Yonker, 2011)

What We Need to Better Understand:
A Recent Research Agenda

• What is the nature of family conflict at end of life (what is it about)?
• What precipitates or contributes to conflict?
• What are the consequences?

Hospice Study
(Boelk & Kramer, 2012)

• Mixed Method Case study
• Designed to replicate & extend Elder Care study to:
  – Advance theory
  – Examine correlates & predictors of conflict
  – Hospice setting
  – Gain both professional and family members perspectives

Methods

• Study Setting
  – Non-profit hospice
  – Serving 6 county area
  – Central Wisconsin

Methods continued

• Mixed Methods
  – 10 Focus Groups
  – 161 Family Caregiver Surveys
  – 15 Family Caregiver Interviews
Results

Presence of Family Conflict in 161 admissions
n = 97; (57%)

Presence of Prior conflict; n = 77 (48%)

Topics of Family Disagreements

- Caregiving
- The patient’s condition
- Treatments & procedures
- Medication use
- Life-sustaining measures
- Enrollment decisions
- Location of care
- Post-death decisions
- Family roles & responsibilities
- Family involvement
- Finances & estate
- Communication
- Spirituality
- Coping

Explanatory Matrix of Family Conflict

(Foëx & Kramer, 2012)

Think about how relevant these various examples are to conflict you witness in the nursing home setting

FAMILY CONTEXT

- Historical relationship patterns
- Family involvement in care
- Family demands & resources
- Family structure
- Substance use, abuse, dependency
- Advance care planning & promises made
- Faith traditions & belief systems

Illustration

Historical Relationship Patterns –

My dad always hated me, …never gave me anything but kicks in the ass or a hit in the face…he told me once I was garbage, …I’d always be garbage. You don’t know how many times I often thought, “garbage girl is taking care of you now dad!” … There was sexual abuse in the family that my dad did toward me … and he started in on my sister…to this day I can hardly stand to be in the same room alone with him… but you got to …step up when you’re needed.
**CONDITIONS**

Decline in Health Status and Functioning
- Acute medical crisis
- Elevated frailty

Admission into Hospice/Death Awareness

Absent Family Members “Coming out of the Woodwork”

**CONTRIBUTING FACTORS**

Death Anxiety - Difficulty Integrating Death Awareness

**Contributing Factors continued**

Incongruent Perceptions of Health Status, Needs & Preferences

**Contributing Factors continued**

Efforts to Assert &/or Maintain Control

**Contributing Factors continued**

Communication Constraints

**Contributing Factors continued**

Efforts to Seek Resolution
**Contributing Factors continued**

Family Vying for Estate &/or Position

**Contributing Factors continued**

Role Expectations & Obligations

**CONSEQUENCES**

Restricted or delayed care planning or implementation

**Consequences continued**

Patient wishes and/or quality of care jeopardized

**Consequences continued**

Increased Patient, Family, and/or Team Distress

**Consequences continued**

Diminished Support for Patient and/or Caregiver
Consequences continued

Severed Family Relationships

Implications for Best Practices

Best Practices – Consider all Phases of Conflict Reduction

<table>
<thead>
<tr>
<th>Phase</th>
<th>Definition</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Prevention</td>
<td>Monitoring and/or intervening to stabilize a potential conflict before it escalates</td>
<td>Detecting warning signs. Initiating activities that address contributing factors to avert conflict</td>
</tr>
<tr>
<td>Conflict Management</td>
<td>Minimizing the escalation of conflict</td>
<td>Peace keeping. Identify triggering events. Promptly address, eliminate or resolve issues that trigger conflict - set rules or limits.</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>Encouraging reconciliation of differences</td>
<td>Peace building. Negotiate agreements Mediation</td>
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Best Practice: Encourage Advance Planning Conversations

- May prevent or manage conflict arising from incongruent perceptions of preferences
- Minimizes risk of overtreatment

  • Without conversations, surrogates “tend to make errors of over-treatment, rather than under-treatment” (Moorman, Carr, p.812; Wenger, Shugarman & Wilkinson, 2008).

Best Practice: Routine Admissions Screening

• Identify “Families at Risk” to:
  – Determine extent to which conflict:
    • Already exists
    • Is amenable to change
    • Whether family desires intervention
  – Determine potential for contributing factors to arise

Best Practice: Family Assessment

• Genograms – Mapping the family
Family Relationship Index

Developed by Moos and Moos (1974); modified and adapted (Kissane & Bloch, 2002).

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family members really help and support one another</td>
<td></td>
<td></td>
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<tr>
<td>2. Family members often keep their feelings to themselves.</td>
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<td></td>
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<tr>
<td>3. We fight a lot in our family.</td>
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<td>4. We often seem to be killing time at home.</td>
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<td>5. We say anything we want to around the home.</td>
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<td>6. Family members rarely become openly angry.</td>
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<tr>
<td>7. We put a lot of energy into what we do at home.</td>
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<tr>
<td>8. It is hard to ‘blow off steam’ at home without upsetting somebody.</td>
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<tr>
<td>9. Family members sometimes get so angry they throw things.</td>
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<tr>
<td>10. There is a feeling of togetherness in our family.</td>
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<tr>
<td>11. We tell each other about our personal problems.</td>
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<tr>
<td>12. Family members hardly ever lose their tempers.</td>
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</tbody>
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Scoring Rules:
Cohesiveness = 1 True + 4 False + 7 True + 10 True.
Expressiveness = 2 False + 5 True + 8 False + 11 True.
Absent Conflict = 3 False + 6 True + 9 False + 12 True.
FRI = cohesiveness + expressiveness + absent conflict scores.

“Family Conflict at the End-of-Life” scale (developed by B. J. Kramer)

As you think about the decisions that you and your family are facing regarding your care (or the care of __________), please answer the following questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Some-what</th>
<th>Quite a bit</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Disagree or argue with one another?</td>
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<td></td>
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<tr>
<td>2. Feel resentment toward one another?</td>
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<tr>
<td>3. Feel anger toward one another?</td>
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<tr>
<td>4. Insult or yell at one another?</td>
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</tbody>
</table>

Best Practice: Engage & Disseminate Information to “Identified Family”

• Don’t assume family members are communicating
• Offspring differ significantly from their parents in perceptions of family communication

[Kissane et al., 1994]

Family Member Quotes

“Nobody has reached out to her...and we don’t understand why...They could have reached out to a sibling who is disengaged...she won’t talk to us...”

“I think it would be nice if maybe, like [the social worker]...calling the other kids, and saying “hey, how are you doing? Is there anything you wanna talk about?” Because I don’t know if they would go and initiate it themselves.”

Best Practice: Routine Family Conferences

“Of the interventions identified..., the importance of regular, properly managed family conferences or meetings as a mean of preventing and managing EOL conflict has the strongest evidence base”

(CREL5 project, 2010, p. 27)

Family Member Quote

“Ongoing family meetings would probably be a good idea, because then people talk, and sometimes you need a mediator to bring these things out....one on one just doesn’t help the whole workings of it.”
Purpose of Family Conferences

Provide and Share Information
a. Medical updates
b. Educate - correct misinformation
c. Get everyone on “same page”

Facilitate Decision-Making & Planning

Address Affective Needs
a. Normalize feelings
b. Provide opportunities for expression and reconciliation

Facilitating the Family Conference: The Process

Excellent Resource: “Family Meetings in Palliative Care: Multidisciplinary Clinical Practice Guidelines” (See Hudson, Quinn, O’Hanlon & Aranda, 2008)

Elements for Successful Conferences

• Pre-planning
• Common goals & agenda confirmed
• Realistic expectations
• Key team members present
• Designated chairperson
• Awareness of the family struggle
• Use of emotionally supportive behaviors
• Inclusion of all significant family members
• Careful communication

(Atkinson, Stewart & Gardner, 1980; Curtis et al., 2002; Dugan, 1995; Fineberg, Kawashima, & Asch, 2011; Hudson et al., 2008; Schmall & Pratt, 1989)

Best Practice: Adhere to General Principles of Conflict Management

• Maintain flexibility
• Maintain neutrality, transparency and professionalism
• Avoid splitting
• Avoid demonizing
• Set necessary limits

(see Holst, Lundgren, Olsen & Ishoy, 2007, p. 42)

Best Practice: Principled Negotiation for Conflict Resolution

Four Principles

1. Separate the people (i.e., relationship issues, perceptions, emotions, communication problems) from the problem (i.e., substantive problems).
2. Focus on interests, not positions (reframing problems).
   “Your position is something you have decided upon. Your interests are what caused you to so decide” (Fisher & Ury, 1992, p. 42).

3. Invent options for mutual gain (proposing solutions)

4. Outlining/using objective criteria when available (e.g., research evidence, position statements regarding care standards)
Admission / Discharge Processes