Conflict in Assisted Living: The Promise of Elder Mediation

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AK, ZP, FG, and a number of long-standing residents in an assisted living (AL) facility ignored SU, a resident. They were rude and treated her with disdain. When a staff member inquired about the situation, she was told that SU's personal hygiene and apartment maintenance was not up to standards. After a few weeks, staff noted that SU stayed in her room and asked to take her meals in a private dining area.

Two nurses and one nursing assistant were summoned by the nursing supervisor to discuss the reason why Mr. S, a physically disabled but cognitively alert middle-aged resident of an AL center, has told his sister and brother-in-law that he never gets any special attention from the staff. They were told that there would be opportunities for Mr. S to interact with other residents that were capable of normal social interactions. The family is threatening third-party intervention.

Mr. Y did not wish to sell his house, give up his hobbies, and enter an AL facility, but he agreed to this decision after a medical crisis. Stable now, he is visited regularly by one daughter. She cleaned out and orchestrated the sale of his house and settled him into his new room at the AL facility. She frequently visits and communicates with the facility staff. His other daughter recently visited after a 2-year hiatus and talks with her father about how he was robbed of his assets by the caregiving sister. She repeats this story to staff and visitors—anyone who will listen. Mr. Y has recently become more and more negative about the staff and facility.

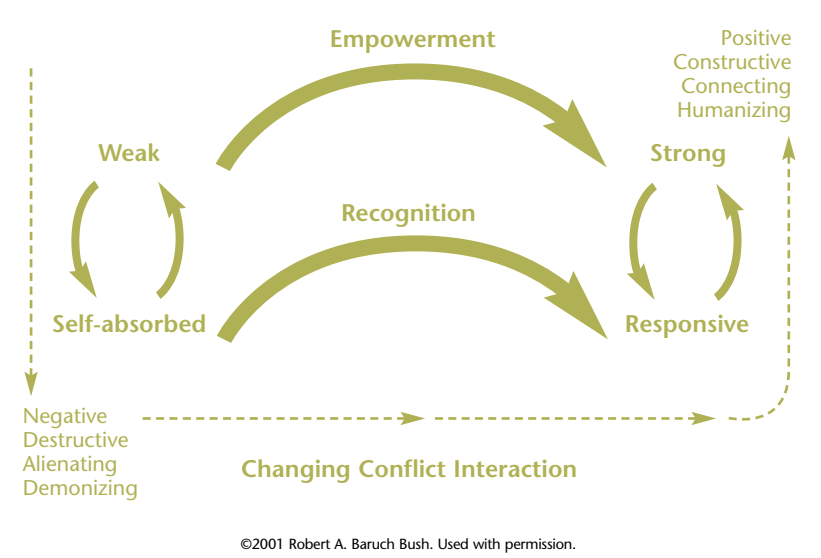
Conflict

Conflict has been defined as a "crisis of deterioration" in human interaction that is significant and disturbing to the involved parties.[1] The crisis can come on quickly and escalate into a major break in communication, heated by others who perceive the dispute in relation to their own culture, values, interests, and needs. Individuals in conflict often feel vulnerable and powerless. An objective observer might characterize their behavior as one-sided and even defensive and self-absorbed. But an increasingly popular intervention method being used in conflict situations within elder care is mediation. Mediation is a conflict resolution

process wherein a neutral, specially trained third party works with disputants to help them communicate more effectively in the midst of conflict. The process is designed to encourage disputants to find their own solutions and seek ways to shift the quality of their interactions. Even elders with diminished capacities can be included in a mediation process using an adapted strategy and advocates.

The use of mediation is expanding into AL and long-term care (LTC) settings as a strategy to reduce the human and financial costs that conflicts exact from their organizations. Mediation provides a means for administration, staff, residents, and families to change their communication patterns, avoid costly litigation, and minimize the stress and harm of an ongoing conflict.[2] There are different models of mediation; an effective model in older adult residential care is "transformative mediation," which is a relational model. This approach goes beyond simple problem solving. Mediators strive to support those in conflict to improve the way they relate to one another, thus providing a basis for increased competency in addressing future disputes. Even if a mediation does not end in agreement, disputants may experience a dynamic shift from feelings of weakness and fear to strength and empowerment as each party expresses his or her perspective in the presence of the mediator and other parties.

Figure 1.
The Potential of Conflict Intervention



Mediation

Participation in mediation is voluntary and confidential. Mediators do not enforce laws, regulations, or agreements; instead they assist people in making their own decisions. They help participants move from the chaos of conflict to a clearer, calmer, and more organized state that is conducive to sound decision making. Mediators are outsiders who listen attentively to all disputants and convey their focused concern for all parties. This objectivity and desire to hear everyone equally opens possibilities for communication where none existed before.[1,3]

Just being heard by an independent party can be beneficial. Mediators look for the slightest verbal and nonverbal cues to signal a shift in a disputant's perspective about the conflict.[4] A glance to acknowledge a statement, a shift in body position, or a softer way of expressing hurt or anger may be a preliminary but significant signal that a disputant recognizes, even if momentarily or partially, the other person's perspective. When this occurs, there may be a change in communication patterns as energy is freed up for "getting clear" about the conflict. This leads to more openness to other ideas and some empathy for the other party. Positive conflict resolution is humanizing, leading to a sense of greater connection and hopefulness.[1] Kathryn Mariani, a seasoned mediator, calls this the "cherished part of conflict resolution."

Most people are familiar with a solution-oriented, linear conflict resolution style. Here the goal is to get parties to agree, but this outcome may not satisfy people who feel compromised or threatened by a perceived wrong.[5] The Institute for the Study of Conflict Transformation (ISCT), a national think-tank on conflict interaction that developed the transformative model of mediation, describes how disputing parties claim that the opportunity to express emotions, feel heard, and contribute to decision making is as important as the end result. Dorothy Della Noce supports the notion underlying transformative mediation that empowerment and recognition create a dynamic interplay of tension between focus on the self and recognition of another person's needs.[6] As one moves toward a position of strength, self-absorption decreases and each participant is more able to ponder the perspective of the other disputant (Figure 1).

Interest in Elder Mediation Grows

The use of mediation to address conflicts involving older adults, their families, and care providers is rapidly growing across the country. Public interest rises with the increased number of elders. Recent airing of national news segments on elder mediation stimulated more public interest.

Table 1.
Types of Conflicts That Can Be Mediated

Issues	Initiating Party	Examples	Possible Disputants
Medical care and treatment	Individual elder Family/caregivers	Staff not following medication regimen	Elders, family members, caregivers, administrators, and professional and nonprofessional staff
Quality of care concerns	Individual elder Family/caregivers	Complaints about facility services, regulations, or costs	Elders, family members, caregivers, administrators, and professional and nonprofessional staff
End-of-life decision making	Individual elder Family/caregivers Medical staff	Elders and others clash in values, religious beliefs, and medical intervention vs. autonomy.	Elders, family members, and caregivers vs. staff and/or professional staff
Noncompliance with treatment plan or facility regulations	Individual elder Family/caregivers	Elders and family/caregivers differ in perception of efficiency vs needs.	Elders, family/caregivers vs staff and administrators
Space use and resource availability	Elders Staff	Staff desire to exclude residents from dining hall.	Elder vs. elder Staff vs. elder
Level of competence	Elder Family/caregivers Staff and professional staff	Elder desires to retain financial decision making.	Elder vs. family Elder vs. staff
Aggressive resident	Elder	Elder fears entering activity room.	Elder vs. elder
Family grievances	Elder Family/caregivers Staff and professional staff	One faction of family disagrees with a policy or procedure.	Elders, family/caregivers vs. staff and administrators
Cultural differences	Elders Family/caregivers Staff administrators	Elder objects to menu choices on religious grounds.	Elders, family/caregivers vs. staff and administrators, or staff vs staff and administrators
Discharge issues	Elders Family/caregivers Staff administrators	Facility plans resident/patient's discharge before family feels ready for elder to return home.	Elders, family/caregivers vs. staff and administrators or third-party payers
Workplace issues	Direct care staff Medical staff Auxiliary staff Support staff Administration	Personality clashes between staff members impact morale and quality of care.	All levels of staff

Elder disputes are commonplace and start with familiar disagreements such as the sale of the family home, sharing of caregiving responsibilities, and financial decisions.[7]

Need for Conflict Resolution in AL and LTC Settings

While many administrators and staff are, by and large, unfamiliar with the mediation process, goals, and potential outcomes, they are keenly aware of the need for and benefits of addressing conflicts arising during the provision of care. Where acute care is focused principally on the patient's medical needs, care in AL and LTC settings is concerned with the global well-being of the care recipient. The array of decisions therefore extends well beyond healthcare choices to the much broader issues of everyday living.

Second, multiple party involvement in care planning discussions presents an increased opportunity for conflicting understandings and intentions regarding the overall goals of care and the choice of options for achieving those goals. Because LTC is continual and on-going rather than episodic, resolving conflicts in a way that strengthens rather

than threatens the integrity of the relationship between care receiver and his family, friends, multiple caregivers, and, in the case of AL and nursing home care, other residents, is especially important and essential to care recipients' well-being.

Types of Conflicts in LTC and AL Settings

In LTC and AL facilities, conflict can occur between staff and resident and/or family members, between resident and family members, between staff and staff, staff and administration, and multiple other combinations of players. Combine hierarchical structure, understaffing, heavy workloads, and the stress of people living together—many in a crisis mode—and you have a hotbed for misunderstandings of injury and harm.[8] While some administrators are concerned about the resources needed for mediation, others take a broader view and balance this short-term cost with the long-term deleterious effects of unaddressed conflicts. These chronic disagreements reappear in different forms because the disputants did not address their differences. LTC and AL facility managers are recognizing that it might be better to take 3 or 4 hours of time to plan, schedule, prepare for, and hold a mediation to avoid future conflicts. Using this line of reasoning, mediation is regarded as a form of risk management.[9]

Table 1 depicts the complexity of issues that can be mediated. The number of disputants may be two individuals or multiple parties such as a large family and members of medical, support, and administrative staff. Issues that are religious or involve ethics can also be ameliorated by a mediation process, as can potential malpractice claims and reimbursement complaints.

Intervention Choices

There are two levels of conflict resolution that can be used in an AL facility. The first is to offer an in-house conflict resolution program and the second is to contact a trained mediator. Staff may be trained in conflict resolution using mediation behaviors such as active listening and objectivity to handle disagreements in ways that promote optimal communication and collaboration. Examples are including the resident and other pertinent people in major decisions, finding a neutral private place to discuss sensitive issues, and allowing different points of view to be aired during discussions without judgment. An in-house program will support open dialogue during the admissions or discharge process in the dining hall, on the floor, and at the bedside.

Given the nature of AL and LTC environments, staff members are bound to find themselves directly involved in conflict. An in-house conflict resolution program should include training to help staff members become aware of their own conflict style such as avoidance, blaming, or aggression. Research indicates that staff and residents use similar conflict resolution styles. Most prefer cooperative means to resolve conflict but training helps to lessen differences that compromise communication and conflict resolution.[10] Staff can learn methods to be less reactive such as taking a deep breath and listening instead of defending or arguing. These approaches help all involved to feel recognized and make choices. If a pernicious conflict develops, it may be useful to contact an outside mediator to set up a structured session. The outsider should have special training and experience in the LTC or AL settings.

Table 2.
Questions to Determine an Appropriate Intervention

- How intense are the emotions?
- Is the dispute an institutional matter or a personal conflict?
- Does the conflict have ethical dimensions?
- Is there the threat of legal action?
- How is the staff member perceived?
- What is needed to have a productive conversation?
- Who needs to be a part of the conversation?
- Who is the best person to facilitate the discussion?

Determining an Appropriate Intervention

When conflict occurs, staff and administration may need to take the pulse of a given conflict situation to determine the appropriate intervention (Table 2). It is best if staff members learn to reflect on how their emotions and position impact the conflict and consider whether they can effectively engage as facilitators of conflict resolution. They must evaluate how objective they can be and how they will be perceived by participants in the dispute. How are their feelings about a particular resident/patient or family affecting the conflict?[11] Do they feel a personal stake in the outcome? Perhaps someone from another department, a member of the ethics committee, or a support staff person would make an effective intervener. Would the patient/resident or family members rather have someone from outside the institution involved to ensure impartiality? In this case, an outside trained mediator should be involved.

Another reason to engage an outside mediator is when regulations, institutional policies, and/or medical and ethical issues bear on the conflict. In such a case, AL staff members are better as members of the discussion instead of facilitators.

The following is an example: *JV is an 84-year-old man who moved into an AL facility after the death of his wife. He worked as a landscaper and developed diabetes 25 years ago. Two months after entering the facility, JV develops cellulitis in his left leg. It is painful and requires daily care. Unmoved by the entreaties of AL staff, family, and doctors, JV refuses some aspects of wound care and claims that he cannot afford the medications and extra attention.* An outside mediator would promote a dialogue without an obligation to advocate for the patient's autonomy or medical needs.

Other instances when professional mediators may help are cases in which impartiality is vital because anyone associated with the institution is regarded with suspicion. Outside mediation may help when a dispute has reached an impasse and positions are locked and unmoving.

Table 3.
Developing a Conflict Resolution Program

- Introduce the concept of mediation and mediative approach.
- Encourage dialogue across levels of staff about conflict in the workplace and how a conflict resolution program will fit best within the culture of the institution.
- Hold a 3-day basic mediation skills training workshop for selected staff to serve as in-house mediators.
- Provide training in communication strategies for all staff to increase competency to communicate effectively and prevent conflict.
- Consider the organizational structure to clarify the roles of resident/family councils, ethics committees, support staff, and outside resources in conflict resolution.
- Provide guidance to staff about when and how to make a referral to an outside mediator.
- Review marketing and admissions materials to be sure they support congruency between consumer expectations and services delivered.
- Develop written conflict resolution policies for employees and consumers.
- Provide on-going continuing education and program maintenance.

Mediation Process

The process can be initiated by any disputant by contacting a local conflict resolution center, mediator in private practice, or a specialized legal or social work practice that offers mediation services. A trained mediator will conduct an intake interview with each of the disputants to determine if each party is willing to participate in a dance of communication and learn about what each perceives necessary for a productive conversation. All parties involved will take part in determining the who, what, where, and how of the mediation session. The mediator may work alone or with a partner. Notes are taken and shared with a partner and if both parties agree, the mediation is scheduled. If legal matters are part of the dispute, an attorney may attend the mediation. An example is the potential sale and transfer of property or an end-of-life decision. A representative from a government or community agency might also participate to clarify information, such as eligibility for services.

An important aspect of the mediation process is the participation of the older adult, even if capacity issues are present, such as in the following example: *Mrs. Duke is a 92-year-old woman who lives in a New Jersey AL facility near a large medical facility. Her children HU and SI live in different states and are fighting over oversight of their mother because they are concerned about her mild dementia. HU lives in Maine and SI lives nearby but in another state. HU wants to move Mrs. Duke to Maine because she can take care of her mother as her dementia worsens. HU has always had an emotionally close relationship to her mother but has not visited too often in the past 5 years because of family and work obligations. SI was given status as agent under Power of Attorney (POA) and is handling Mrs. Duke's financial affairs. Accusations are flying about the motives of SI in trying to keep their mother in the AL facility and his role as the POA. A meeting is held at the AL residence to ensure Mrs. Duke's participation. During the meeting she smiles and hugs both children and expresses her attachment to the staff and facility. At one point she becomes agitated when an argument erupts between the siblings. She shouts that she wants everyone to get along. This has a profound effect on the mediation and even in this limited role, Mrs. Duke exerts a powerful effect on the outcome. The siblings decide to work together and keep their mother at the facility. SI agrees to pay for HU's trips to visit their mother.*

Mediation may be a one-time event that fosters change in a conflict that occurred over many years or it may take a number of meetings. Mediation can begin new interaction patterns, or the issue may be resolved and the disputants never interact again. Once mediation is completed, there is an evaluation process that may involve a written survey or personal interview.

How to Develop a Conflict Resolution Program

The best way to introduce mediation and a mediative approach into an institutional setting is to form

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make myself dangerous to my input, my computer, and myself.

For the past 2 weeks, I have been on the Alzheimer's mashed potatoes and green beans speaking circuit (spent a week in Florida and a week in Iowa).

"How was I going to answer my e-mail? How was I going to write about new experiences? I cannot read my own handwriting, nor can anyone else. I know—I'll buy a laptop computer." So I did.

Now I do not consider my current height of 6'5" tall as making me a giant. Apparently people who design laptop computers do. When I attempted to manipulate the mouse to move the little arrow icon on my screen, my fingers made me feel as if I was someone a little bigger than Shrek and a little smaller than the person who chased Jack down the beanstalk. After 2 weeks of relearning how to control the index finger on my right hand, I was close to being incompetent when using my laptop.

Okay, then I returned home. I sat down at my computer and wanted to check my E-mail. I looked at the screen—I looked at the keyboard—I looked at the screen—I looked at the keyboard. I looked at my desk. I looked at the keyboard. Where was the tiny little pad to be found upon which I could lay my finger to move that little arrow where I wanted it to be? Honest, I looked for 15 minutes straight for some way to move that arrow by doing something on or to my keyboard. In fact, I had completely forgotten not just how to use the mouse, but that the mouse was a replacement for my finger. I actually looked at the mouse many times while I was searching the keyboard. No light went off—no bell rang.

Even now, a week later, I am uneasy when I first sit down at my desk and turn on my computer. There is a knot in my stomach—or is it my throat or maybe both—that I cannot seem to cough up. This is one of a hundred incidents of confusion and memory failure that occur every day. This is one of 95 incidents that people around me are unaware of.

I did not forget how to use the computer; I could only remember how to move the arrow on my laptop. Alzheimer's disease is much more complicated than just forgetting. If that were the case, reminders and cues would be the best medicine. Dr. Alzheimer scrambles a faulty executive function, creating temporary loss of common sense and memory loss. The result is me sitting at my computer with a lump in my throat and my stomach.

Now this may seem to some people like making an elephant out of a mouse. To me, incidents like this were initially an annoyance. Then I got frustrated. And now, I cannot get rid of this knot in my throat and my stomach. I am scared. If I completely and totally forgot about the mouse and how to use it, what will I forget about tomorrow? ALC

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partnerships among mediation providers, advocacy groups for older adults, and the institution. Programs should use a multilevel approach to establish conflict resolution policies and protocols across the institution (Table 3). For more information, contact the Montgomery County Mediation Center (www.mediation-services.org) and The Center for the Rights and Interests of the Elderly (www.carie.org).

Conclusion

Demographic trends and directions in the field of LTC and AL point to an increasingly important role for mediation. Longer life expectancies and the "baby boom" bubble will result in a dramatic increase in the number of older Americans residing in LTC and AL facilities. Although everyone hopes to avoid conflict and communication problems, mediation offers another tool to keep the morale of staff and residents high and reduce the difficulties of needing legal means to resolve conflict. ALC

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References

1. Baruch RAB, Folger JP. *The Promise of Mediation: The Transformative Approach to Conflict*. San Francisco: Jossey-Bass; 2005.

2. Whitenack SB. Using elder mediation to resolve conflicts involving the elderly. *The Elder Law Report*. 2005;17(3):1.

3. Cronk E, Conrad R. (Eds.) *Mediator's Handbook*. Langhorne, PA: Bucks County Mediation Services; 1998.

4. Mediation Practice: The Transformative Framework. The Institute for the Study of Conflict Transformation, Inc. 2002.

5. Small JA, Montoro-Rodriguez J. Conflict resolution styles: a comparison of assisted living and nursing home facilities. *J Gerontol Nurs*. 2006;32(1):39-45.

6. Della Noce DJ. Mediation as a transformative process: insights on structure and movement. In: Folger JP, Baruch Bush RA. (Eds.) *Designing Mediation: Approaches to Training and Practice Within a Transformative Framework*. NY: Institute for the Study of Conflict Transformation; 2001.

7. Gage D, Martin D. The benefits of mediated family estate-planning retreats. *ACResolution*. Summer 2005 (18).

8. Denenberg T, Denenberg RV. Curing conflict in the health care industry. *Dispute Resolution Journal*. 1999;54(2).

9. Marziali E, Brcko C, Climans R, Consky A, Munro M, Tafler M. Negotiating relationship contexts in gerontological social work practice. *J Gerontol Soc Work*. 2005;46(2):51-68.

10. Gladstone J, Wexler E. A family perspective of family/staff interaction in long-term care facilities. *Geriatr Nurs*. 2000 Jan-Feb;21(1):16-19.

11. Wood E. Addressing capacity: what is the role of the mediator? Mediate.com Web site. http://www.mediate.com/articles/woodE1.cfm. Accessed November 2, 2007.