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An exploration of multiparty dispute resolution when the impending death of a loved one creates an escalation in family conflict

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Lines of humans not hubris

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Lines of Humus not Hubris

When my latest breath is drawn
Take not time to weep.
Lay me, bare as I was born
on my compost heap.

Babble not of dust to dust
Make no holy fuss,
Let my epitaph be just
'Human to humus'

Pray you, as you go your ways,
Wielding spade or hoe
Spare me just one word of praise
Busy there below.[1]

Introduction

High levels of family conflict are often experienced by family members around the impending death of a loved one.

Recent research suggests that dispute resolution processes can help families deal with conflict arising out of grief. It was also hoped that the research will become a launching point for further research into mediation practices where multiparty dispute resolution is indicated, and provide assistance to families and carers struggling with anticipatory grief and escalating family conflict around the impending death of a loved one.

The scope of the research was limited to family relationships where the impending death of an elderly patient (parent) created an escalation in family conflict between family members (siblings). Informal interviews were conducted with nursing home and hospice staff (four interviewees) from four different facilities: palliative care; aged care; disability services; and dementia care. Facility staff were chosen to be interviewed rather than patients and families, to avoid intrusion into family privacy at such a sensitive time in the patient's life and because of strict facility privacy legislation. The research sample chosen was small and random in order to focus on the narratives expressed by each staff member (interviewee).

The possibility of providing effective dispute resolution for families and staff members when the death of a loved one was imminent and there is an escalation in family conflict was explored. The major point being that the health professional can play a significant role in bridging the gap for peace when there is an escalation in family conflict.

The Institute for Resource and Security Studies briefing manual (2000) concludes that:

> Medical professionals have a social role to play in healing violence ravaged communities. They can do much to heal a community's damaged sense of wholeness by creating peacetime bridges between groups who have been in conflict … Healthcare providers can create a bridge between conflicting communities, whereby delivery of healthcare can become a common objective and a binding commitment for continued cooperation … Many practitioners, in particular psychosocial specialists, have specialized knowledge and unique skills, which can contribute to a culture-specific process of acknowledgement, mourning and grieving about the past.[2]

Definition of terms used in this research

Grief

Worden approaches grief as a personal experience of loss; the process of experiencing the physical, social, and psychological reactions to the perception of loss.[3]

Family systems

Goding describes the family system as comprising individual members each with their special characteristics, together with their relationships and interactions with the family.[4]

Multiparty dispute resolution

Multiparty dispute resolution is defined by Webne-Behran as mediating conflict between multiple parties.[5]

Anticipatory grief

Raphael states that anticipatory grief is often experienced where there is knowledge beforehand that death is probable or inevitable in the near future.[6]

To discover how best to assist families at the time of impending death of a loved one it is important for mediators, nursing home staff, and other readers to have a background understanding of families and grief. This includes the anticipatory grief experienced by patients (parent), siblings, and the impact of grief experienced within family systems.

Webne-Behner in his guidelines for mediating multiparty disputes emphasises that it is important for the mediator to spend extra time in pre-negotiation and needs assessment, to

help gain a sincere commitment to the process from all participants. He suggests that clarification of how the issues are perceived from the various vantage points of the parties will minimise surprise factors at the point of discussion.[7]

Possible indications for the use of multiparty dispute resolution were explored through the staff interviews conducted. A mediator checklist (see Appendix 1 to this article) for families and mediators was developed to assist family members and caregivers acknowledge and normalise grief and the conflict experienced. It was hoped this questionnaire could be further developed as an educative tool to alert families to possibilities for conflict resolution or alternative pathways to peace.

Benjamin in his article, 'The physics of mediation', believes that family issues are now being scrutinised as conflicts appropriate for mediation.

Mediation requires a different thinking frame that cuts across the traditional established disciplines. Psychologists, social workers, sociologists, social policy analysts, lawyers, court administrators, and political scientists all came to the realisation that the traditional practice models of their separate disciplines were inadequate effectively to understand, accommodate, and resolve conflict. That inadequacy was especially clear where families were concerned.[8]

In adult life the death of a parent has previously been viewed as something that should be accepted, a source of grief but not of difficulty. The valuable work of Horowitz et al[9] shows how stressful the bereavements following such deaths may be for many adults. Horowitz and Raphael found that the death of a parent was:

> A serious life event leading to measurable symptomatic distress in many persons, including those who did not seek therapy.[10]

This distress exacerbates the significant grief family members are already experiencing with the breakdown of valuable support networks at a time when increased support is important.[11]

Understanding family functioning and grief is important both for the staff and caregivers involved in these situations, and mediators invited to assist with family dispute resolution.

Families and grief

The patient (parent)

Raphael states:

> As life draws to its end, the aging person faces another death … the death of 'self'. There may be partial deaths along the way like the failing of body parts … This sense of finitude leads the older person to an increasing occupation with death. How will it come? When will it come?
>
> Sometimes there are fears, a wish to turn away from it; other times a desperate need to talk about it … There is a growing perception of the aloneness of death. Sometimes it is looked for as a friend: 'I am ready for death' says the old man. The processes leading up to this preparedness for death in old age are really those of anticipatory grief.[12]

It was not the intention of the writer of this article to discuss anticipatory grief (see explanation in definitions); however it would be in the reader's best interests to gain an understanding of this concept. Families of those patients facing death and experiencing high levels of conflict could be given education, and an opportunity to understand the nature of the grieving process and its impact on the family. How the mediator understands the patient's emotional status and the impact of gender is also significant.

The siblings and family systems

A complication to grief and bereavement processes can exacerbate the relationship as family members and others struggle to understand what is happening on a psychosocial level to their loved one. The concept of complicated bereavement risk is based on *associations* and therefore does not come with a guarantee of negative outcomes.[13] Parties involved in any mediation processes may need to be screened for suitability and the possible impact of their mental and physical health on the mediation process.

General systems theory states that a person and situation is a whole unit, and parts of that whole interrelate with parts of society. Intervention with one part of the system can often cause an effect or change on the entire system.[14] Patterns of interactions are based on rules or injunctions about behaviour within a system and violation of these rules has consequences as the system has power to limit individual expression. Systems may be open or closed depending on the degree to which they are willing to interact with the outside environment.

While mediation is future focused, it is important to ensure that issues from the past are discussed before decisions can be made about the future. Family therapy or individual counselling of subsystems may be recommended before mediation can occur to sort out complex family issues.

Attachment and the experience of loss also impacts siblings and families. Waskowic and Chartier reported that secure people reminisced and had more interchanges with the deceased, and as a whole attachment style had an effect on one's grief reaction.[15]

A vulnerable family struggling with attachment issues may need counselling before mediation can take place. The impact of attachment issues also gives rise to the need for parties to be given an opportunity to speak directly with their parent, which is often overlooked during times of high conflict (see question in Appendix 1 at the end of this article).

The question as to whether a person would like an opportunity to speak with their parent about their impending death introduces us to the important role of care givers and health care providers attending and supporting patients and their families.

The role of care givers and health care providers

Health care providers face many issues when conflict arises. The main problems staff identified included the distress family conflict caused for health workers and the patient, difficulty in juggling psychosocial patient care and medical responsibilities, and facilitating good decision making processes for the dying patients.

Decision making around the impending death of a loved one had a significant impact on care givers, health professionals and the patient's family. The staff interviewed reported that nursing staff often 'tiptoed' around family members and felt responsibility for information giving. The weight of this responsibility was evident when it was observed that the 'wrong

information given to the wrong person in the family' could escalate family conflict and grief. Nursing staff struggled to balance family secrets and subsystem boundaries, the patients' best interests and professional requirements.

An article in the *American Journal of Critical Care* identified problems that nurses faced while caring for families.[16] Problems involved juggling patient/family barriers and system/ team barriers. One interviewee working in disability services reported that 'this was less of a problem in disability services as there was often only one patient carer to consider'.

The barriers to effective dispute resolution that most interviewees reported included the impact of anticipatory grief, and the person's own issues:

> 'Families don't want to, or are not ready to, deal with disputes at this time. Also pride. They don't need anyone else to sort out their problem. A failure to see reality and being in denial about serious issues.'
>
> 'Holding onto grudges from the past was the greatest barrier.'

A patient's end-of-life wishes have implications for administrators, regulators, and families. Medical decision making around the time of death also has a significant impact for the patient, staff and families. One interviewee commented that the use of living wills assists in reducing conflict. The fear of litigation was flagged by two interviewees as a barrier to dispute resolution practice.

How dispute resolution can assist parties experiencing grief

A facilitative mediation approach could be utilised by trained facility staff who are free from the dual responsibilities of caring for patients while attending to psychosocial issues involved in escalating family disputes.

Most staff indicated that with management permission they would value some training in the skills required for mediation or conflict management.

One interviewee said:

> 'We often get training in medical or palliative care, but not in how to deal with the family issues. The patient is their first responsibility and with conflicts of interests this can become very difficult.'

Opportunities could be provided by facilities to engage skilled mediators for multiparty dispute resolution when family subsystems and multiple parties are involved in escalating conflict.

The interviews conducted suggested that there was a large variation in families' experiences in the facilities, regarding the percentage of patients experiencing an escalation in family conflict. The percentage range reported was from 10 to 90 per cent of residents. When interviewees were invited to recall their experiences of family conflict they reported:

> 'Issues especially for parents' children are anger and grief at loss and abandonment. This can lead to sudden possessiveness of family members when a loved one is dying.'
>
> 'My memories over disputes between siblings are over who gets what!'
>
> 'It has the opposite effect in some instances and families tend to pull together well.'

When consulted about who should be involved in multiparty dispute resolution, most interviewees agreed that the patients (parents) themselves should be consulted about their wishes, but not directly involved as it would be too stressful for them. Involving the patient may also assist them to further explore the narrative of 'the self of dying' Chatergee referred to in the task of meaning-making for patients at the end stages of life.[17]

All staff agreed that the *patients' voices* should be heard, and ways to involve them in the mediation process should be explored. Perhaps a similar process to *Family Law Mediation,* where the '*child's voice*' is heard without being present at the mediation, could be woven into the mediation design to ensure the *patient's voice* was heard? How this might be achieved would require further exploration. All the interviewees stated that:

> 'The dying are often confronted with their own stuff if unwell or dying at this time.'

Most interviewees agreed that the family or willing parts should be involved in the mediation process with input from consultants and nurses when requested. All interviewees agreed that it was important to ensure that the family was aware of the grief family disputes caused for the elderly parent, and that it was important for social workers, nurses, and allied health professionals to be involved.

Interviewees commented:

> 'Nursing and other staff found these family disputes very stressful. The patient was their first priority but with family conflict this was made very difficult especially for the patient experiencing difficulty facing their own death and if they are leaving a disaster behind for the family in terms of conflict.'

Webne-Behre suggests in 'Guidelines for mediating multi-party disputes' that it is important to seek common ground early, to clarify areas of difference.[18] Trained nursing staff could be equipped to assist families move to a position of clarification, where support could be built for continued dialogue with parties involved.

Benjamin in his article 'The physics of mediation' states that:

> The emphasis should be on defining and enhancing the competency of the mediator practice rather than merely professionalizing practice.[19]

Some constraints on the use of multiparty dispute resolution for families might include *closed family systems*. Also the impending death of a loved one and the acute grief reactions experienced by family members may overpower any clarification of key issues families may wish to resolve. There may also not be enough consensus between family subsystems to impact decision-making and dispute resolution.

Impending death, while a challenge for families and others, could also be a very powerful lever to facilitate discussion regarding end of life matters and resolution of family of origin issues. The parties concerned would need to be able take up personal counselling if unfinished family matters impinged on the mediation process or the patient died before mediation could be completed.

Multiparty dispute resolution could assist families resolve conflict around the impending death of a loved one, and give parties opportunities to acknowledge and realise their grief in a safe contained environment, while keeping future focused on the important issues up for discussion.

The value of a mediator's checklist

The mediator's checklist (Appendix 1) could be developed further to assist nursing staff or carers to ascertain a

family's 'readiness' for the possibility of multiparty dispute resolution if indicated. Most staff commented on the value of a checklist so patients and their families have an opportunity to resolve issues before the family member dies. Crisis can provide an opportunity for change that may have lasting impact on all family members for future generations.

The problem may need to be attacked another way if the parties in dispute are not willing, or not able, to participate in a voluntary capacity. This might include the family mutually agreeing to appoint a wise family member or friend who is well respected by all parties to offer insight, speak with the patient, and engage all parties concerned.

A thorough education for families entering facilities with information on anticipatory grief, the patient's needs, and opportunity for dealing with their own personal and historical issues in a professional counselling or mediation setting may be helpful. The value of family cohesiveness at this time could also be highlighted.

Appendix 1
Mediator's Checklist

Some questions to assist families considering mediation when escalations in family conflict threaten the health and wellbeing of the patient and their family.

- ☐ Where does your family stand within the scope of open and closed systems? (Scaling continuum: closed_____5_____open)
- ☐ Are you willing to receive input, education, and mediation from other communities/systems? (e.g. care givers, mediators, professional staff, and therapists)
- ☐ What rules does your family have about making rules?
- ☐ Who have been the decision makers in your family, and how would you feel if that changed?
- ☐ Are the boundaries open enough in your family to permit contact between members of the subsystems and others?
- ☐ If not, what strategies to overcome blockages might be helpful for the mediator or to know about your family?
- ☐ Who would be the best spokesperson/s for your family?
- ☐ Would you like an opportunity to speak with your parent about their impending death? (Support person may be offered.)

Notes for mediators:

Draw a Geno-gram and Eco-map of the family to highlight the nature of various relationships and the nature of the various subsystems, including points of conflict that need to be mediated, bridges that need to be built, and resources that need to be sought and mobilised.

Conclusion

The literature has little information on multiparty dispute resolution for families when there is an escalation in family conflict around the impending death of a loved one. Mediation in this context, the writer believes, is an important area of study that warrants further research.

The role of health care providers in this context is an important vehicle to provide possible pathways toward family peace and a decrease in staff and facility stressors. Information arising from the staff interviews conducted realised several limitations which might impact the ability to conduct multiparty dispute resolution with families.

It appears from the interviews that often family members in dispute are harbouring old grudges or personal issues that have a historical foundation which may not be resolved overnight. Parties would need to be willing to pursue personal work before any mediation could take place. Also parties may not be emotionally available when they are grieving and already feeling overburdened.

The aim of this research was to explore the fertile ground of multiparty dispute resolution, and to nourish families struggling with anticipatory grief and family conflict. The writer is aware that the mediator (informal or professional) faces many complexities and sensitivities in helping families during such a difficult time.

However, a significant understanding of the nature of grief will assist practitioners wrestling with the heart of mediation practice in this difficult context. This will lead to greater understanding of the parties' needs, and has useful applications across a broad range of mediation contexts. ●

Babble not of dust to dust
Make no holy fuss,
Let my epitaph be just
'Human to humus'
(Medley, 1952)

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The writers' experience of family matters surrounding the impending death of her father led to an exploration of this subject. Counselling colleagues, lecturers, and aged care facility staff identified with the common experience of painful family cut-off when family support was most needed. It is hoped that this exploration will assist all those struggling to maintain peace during difficult and painful family transitions.

Endnotes

1. JDG Medley, 1952.
2. Gutlove P (2000) *Health as a Bridge for Peace,* Institute for Resource and Security Studies, May. Retrieved 1/11/06 from <www.irss-usa.org/pages/documents/HBPbriefmanual.pdf> at p 15.
3. Worden J (1995) *Grief Counselling and Grief Therapy, a handbook for the mental health practitioner* (2nd ed) United Kingdom: Routledge.
4. Goding G (1992) *The History and Principles of Family Therapy* (1st ed) Australia: Victorian Association of Family Therapists publication.
5. Webne-Behrman H (1998) *The Practice of Facilitation: Common problems in multi-party disputes*. US: Quantum Books.
6. Raphael B (1996) *The Anatomy of Bereavement, a handbook for the caring professions*, United Kingdom: Routledge.
7. Above note 5.

8. Benjamin R, 'The physics of mediation: reflections of scientific theory in professional mediation practice' (Winter 1990) 8(2) *Mediation Quarterly* at 93.

9. Horowitz et at 1981, cited in Raphael above note 6.

10. Above note 6 at p 309.

11. Above note 6 at p 309, see footnote.

12. Above note 6 at p 317.

13. Gear R, 'Complicated bereavement risk assessment', (Summer 2003–2004) *Periodical of the Christian Counsellors Association of Victoria* 8.

14. Above note 4.

15. Waskowic TD & Chartier BM, 'Attachment and the experience of grief following the loss of a spouse' (2003) 47(1) *The Journal of Death and Dying*.

16. Downey L et al, 'Measuring intensive care nurses' perspectives on family centered end of life care: Evaluation of three questionnaires' (2006) *American Journal of Critical Care*.

17. Chatterjee, 'Understanding the experiential world of dying: limits to sociological research' (2003–2004) 48(3) *The Journal of Death and Dying: Limits Sociological Research*.

18. Above note 5.

19. Above note 8 at 111.

ADR Diary

- The **9th National Mediation Conference**, **'Mediation: Transforming the Landscape'** is being held in Perth from 10-12 September 2008 and is being co-convened by Margaret Halsmith and Chris Stevenson. For more information about the conference schedule and details, visit the website at <www.promaco.com.au/2008/mediation/>.

- **ACDC** is offering a one-day course **Complaint Handling — 'A Complaint is a Gift'** designed to assist front-line staff in service industries in handling complaints. The course is being held in Sydney on 27 March 2008.

- **ACDC** will also hold 5-day mediation workshops entitled **Mediation: Skills, Techniques and Practice** with optional sixth accreditation assessment day. The workshops are taking place in Sydney on 4-8 February, 10-14 March, 5-9 May and 16-20 June with optional accreditation days on 12 February, 18 March, 15 May and 24 June.

- **ACDC** is also offering one-day courses in **Conflict Resolution Dispute Avoidance** in Sydney on 20 February, 8 April, 22 May and 26 June 2008. For more information or booking for any of their courses visit <www.acdcltd.com.au> or call (02) 9267 1000.

- **ACPACS** are holding 5-day **Mediation Workshops** in Melbourne from 26-28 March and 31 March-1 April 2008 and in Brisbane from 14-18 April and 23-27 June.

- **ACPACS** are also running 3-day **Negotiation Workshops** in Melbourne from 17-19 March and 22-24 April and in Brisbane from 1-3 April. A 3-day **Advanced Negotiation workshop** will also be held in Brisbane from 14-16 May.

- **ACPACS** will also hold a 3-day **Complaints Handling Workshop** in Melbourne from the 12-14 May. For more information and to register in classes, visit <www.uq.edu.au>.

- **Bond University Dispute Resolution Centre (BUDRC)** is running a number of courses in 2008. Four-day **Basic Mediation courses** will be held on the Gold Coast on 27-30 March, 31 July-3 August, 16-19 October (Melbourne), 27-30 November.

- An optional 2-day **Assessment course** for those wishing to qualify under the National Standards will be offered by **BUDRC** on 29 Feb-1 March, 16-17 May, 15-16 August and 7-8 November (Melbourne).

- **BUDRC** is also running short 1-day courses on the Gold Coast on 24 April, a **Healthcare Dispute Resolution Workshop**, and on 14 May, a **Conflict in Schools Workshop**.

- **BUDRC** will also run two **4-day Advanced Mediation courses**, the first in conjunction with Leo Cussen Institute in Melbourne on 13-16 March and second on the Gold Coast on 28-31 August.

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