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The management of family conflict in palliative care

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Abstract

We review the literature on family conflict in palliative care. The prevalence and common sources of conflict are discussed, including historical issues of tension, differing coping styles, the division of labour, and the presence of acute or chronic mental illness within the family. Assessment and intervention strategies used in Family Focused Grief Therapy (FFGT), a family-centred preventive intervention that begins during palliative care and continues during bereavement, are presented, with special consideration given to research on treatment decision-making, cultural issues, special-needs populations, and the management of crises within the family. We conclude with a discussion of challenges that frequently impede conflict resolution and with suggestions for addressing these difficulties in the palliative care setting.

Keywords

Family conflict; palliative care; management; Family Focused Grief Therapy

Introduction

Families of palliative care patients face numerous stressors, ranging from critical decisions about medical care to grieving their impending loss. As they endure these circumstances, the family as a whole can be a tremendous resource for each of its members, including the dying patient. However, management of the related practical and emotional burden can result in family conflict. Disputes may increase in frequency as patients approach death, as severity of illness has been found predictive of family strain.¹

Given the critical role of support in moderating medical outcomes and psychological distress,² a conflict within a family can have dire consequences on the well-being of the patient.³ Family conflict can also impact the course of bereavement following the patient's death.⁴ Opportunities to accomplish tasks that are potentially beneficial during palliative care, such as addressing unfinished business, reviewing life accomplishments, expressing gratitude to others, achieving a sense of peace and equanimity, and saying good-bye, may be thwarted in the presence of family conflict and dysfunction. Fortunately, families of patients nearing the end of life can be spurred to come together, and so the palliative phase may be an opportunity to not only resolve conflict, but also to optimise functioning while the patient is still alive to appreciate it.⁵

Regrettably, clinicians are not well-trained in managing conflict in the palliative care setting. Kissane⁶ proposed that the ethical principles emphasised in the Barcelona Declaration,⁷

namely dignity, autonomy, integrity, and vulnerability, are a guide to clinicians to help resolve discrepancies in values and other conflicts that occur among patients, families, and medical staff.⁸ When ethical dilemmas arise in the context of treatment decision-making and patient care, Randall and Downie⁹⁻¹¹ suggest that the needs of the patient be generally prioritised over those of the family.

More specific interventions to manage disagreements have been recommended by Kissane and colleagues,⁵ who have detailed the strategies used in the application of Family Focused Grief Therapy (FFGT). A preventive, systemic model of family grief therapy, FFGT was designed to optimise the family's functioning and promote the sharing of grief. Therapy begins during palliative care and continues beyond the patient's death, terminating when the family has achieved a functional level of cohesiveness, expressiveness, and ability to resolve conflicts.

Prevalence of family conflict

Conflict within a family and between families and staff occurs often in medical care, and palliative care settings may be particularly vulnerable.¹² A study of conflict in intensive care units found that at least one episode of conflict, which included disagreements within the family, between the family and staff, or among staff members, occurred in 78% of the 102 cases examined.¹³ Conflict within the family occurred in 24% of these cases, mostly about decisions around with-holding or withdrawing treatment.¹³ Back and Arnold¹² noted that the amount of time physicians spend managing conflict is significant and likely to be under-reported.¹⁴

The presence of hostility may place families at increased risk for continuing conflict. Kissane *et al.*¹⁵ found significantly higher rates of hostility among the offspring of patients (26%) when compared to spouses (13%) and patients (9%). In a study of adult child care-givers, Strawbridge and Wallhagen¹⁶ observed that 40% of the care-givers had serious conflict with another family member and that sibling conflict was especially common.

Sources of conflict

Various circumstances may produce conflict among the patient's family members. The types of conflict range from competing needs or preferences for communication and truth-telling to more florid psychopathology exacerbated by the stress of the patient's illness. Kramer *et al.*³ pointed out that family conflict is not a unidimensional construct and can be quite complex. Fights can break out because of a perception of insufficient assistance from a particular family member,¹⁶ difficulty agreeing on the co-ordination of patient care, and the resurgence of past tensions.³ Disputes may also emerge when there are difficulties defining which individuals are considered 'family' and determining who should be responsible for making decisions.¹⁷ Collusion is common. Families often request that prognostic information or knowledge of disease progression be kept from the patient.^{18,19} This may happen more frequently among families from Eastern cultures.²⁰

Historical issues

Families are broadly defined in palliative care, and do not simply include biological relations. The 'fictive kin' is whoever the patient and family acknowledge as family.²¹ The use of a genogram helps clinicians understand the nature of important relationships and potential transgenerational issues. Divorce and remarriage result in large, blended families, which may include step-children and step-parents. Such reconstituted groups encounter disagreements when patient care decisions become necessary.¹⁴ Efforts should be made to resolve boundary ambiguity²² in order to clarify which individuals are in the family system. Sources of tensions that arose at time of the divorce or separation can emerge again

(unfinished business) during stressful times. Members fear opening up old wounds, yet an opportunity exists to apologise and heal.

Different styles of coping and levels of emotional expressiveness

The discussion of death may especially provoke conflict when there are differences in coping styles.⁵ Families often pass down legacies of communication and coping styles transgenerationally.^{1,5,23} The previous generations' patterns of communication impact on how the patient and other family members share their concerns with one another. Younger family members can exhibit maladaptive ways of reacting (*e.g.* experiencing an intensified sense of threat) because they witnessed these coping styles throughout their lives. The threat of loss may activate dysfunctional patterns of relating, including over-involvement, detachment, or hostility. Family members may react negatively to an individual expressing distress, especially while managing their own emotional reaction to the impending loss, which further perpetuates insecurity.²³ Insecure attachment styles, which develop out of early relationships in addition to physiological vulnerabilities, are likely to play a role in family members' interactions with one another as well as their reactions to the prospect of losing the patient.²³

Division of labour

Conflict arises when family members feel that an unfair division of labour caring for the patient has occurred. This may be further complicated by feelings of guilt or complaints about burden, resulting in unspoken frustration with those family members who seem less involved. Schofield *et al.*²⁴ found that care-giver burden is more likely to occur when there is family conflict, including resentment and anger at the patient.

Acute or chronic mental illness

Premorbid psychiatric disorders or the onset of mental health problems in the patient or a family member increases the likelihood of conflict and may hinder resolution. Acute illnesses include depressive, anxiety, adjustment, or cognitive disorders. While prevalence estimates vary, one large-scale, multisite study found that 12% of advanced cancer patients²⁵ and 13% of their care-givers²⁶ met criteria for a depressive or anxiety disorder. Vulnerability to substance abuse issues can lead to expression during this stressful time.

Longer-standing character pathology may also lead to family strain. Individuals with features of borderline personality disorder may experience relationship deficits and difficulties regulating their emotions. Patients or family members with paranoid personalities may be overly suspicious and mistrustful of others or the medical team. Hahn *et al.*²⁷ found that 15% of primary care patients were characterised as 'difficult' by their physicians. While differences in presentation between primary care and palliative care can occur, 'difficult' patients or family members are common in palliative settings. Difficult individuals may seek to form an alliance with healthcare providers when there is strain in families; wise clinicians avoid being drawn into taking sides.²⁸ Conflict may be pre-empted or best managed through early recognition of acute psychiatric disorders or long-standing personality dysfunction so that appropriate communication strategies are used and referrals can be made.

Clinical strategies

Assessment

In FFGT, families believed to be at risk for dysfunction are invited to meet together to promote mutual support without burdening them with labels of pathology. Families at risk are recognised by screening with the Family Relationships Index (FRI),^{29,30} which is a 12-

item, true–false, global measure of family interaction based on the cohesiveness, conflict, and expressiveness subscales of Family Environment Scale.²⁹ Families who score 4 or less on the cohesiveness dimension of the FRI or who have a total FRI score of 9 or less (using the ratings of the member with the poorest perception of functioning) are considered at risk for morbid psychosocial outcomes and are invited to meet as a group with a facilitator. The family's level of cohesiveness, communication skills, and ability to resolve conflict (dimensions assessed with the FRI) are used for the purposes of classification. Within society, families are distributed between well-functioning, intermediate, and dysfunctional types – levels of functioning defined in this way are predictive of psychosocial outcomes during the palliative care and bereavement.^{15,31}

Specifically, five classes of families can be distinguished – supportive (33%), conflict resolving (20%), intermediate (33%), hostile (6%), and sullen (9%) families.⁵ Supportive families demonstrate high cohesiveness. Conflict resolvers exhibit strong communication skills, which facilitate the resolution of any differences of opinion. Both supportive and conflict resolving families are considered well-functioning. Intermediate families have more psychosocial morbidity than the well-functioning families and are at increased risk of difficulties following the patient's death. Hostile families use fewer coping strategies assessed via the Family Crisis Oriented Personal Evaluation Scale,³² such the utilisation of social, community, or spiritual support.⁵ This distinguishes them from sullen families, who capitalise on such coping resources despite grieving most intensely and being at highest risk for depression. Dysfunctional family types who may refuse screening include avoidant, withdrawing families and chaotic/alienated families; it is difficult to determine whether screening refusers are declining participation in research or are rejecting clinical intervention.³³

The implementation of routine screening may assist the palliative care team to identify families at risk for poorer outcomes based on their current level of functioning. Assessment of the family's functioning can be made in a routine family meeting through the use of circular questioning,³⁴ which permits the clinician to observe communication patterns and to learn more about individual members' belief systems and roles in the family system. Circular questions invite individuals to observe others and describe their interactional patterns.

Interventions

Clinical interventions may become necessary at several stages during palliative care and thus vary in their aims. They may be applied to assist the family in stabilising life at home and to help family members reach consensus on decisions about the patient's care and estate management before or after death.³⁵ Optimally, family interventions take place preventively or as early on as possible. Families who use focused decision-making and positive conflict resolution may be better able to care for an ill relative.³⁶ Palliative care providers should be trained to assess families and intervene when conflict is evident or probable, so that problems do not escalate, interfere with patient care, or compromise the long-term well-being of any individual.³⁷ Interventions with families exhibiting marked dysfunction are best done in a neutral location.⁵ When developing goals, practitioners must consider wisely how entrenched the patterns of functioning are and formulate realistic goals accordingly.³⁷

Kissane⁶ outlined three potential viewpoints that palliative care providers might consider in managing competing needs: (i) a model centred on the patient's needs; (ii) one in which patients' and family members' needs are given equal attention; or (iii) a model that prioritises patients' and family members' needs based on their respective vulnerabilities at a given time. He emphasised that each approach has costs and benefits and may vary in its ethical appropriateness depending on the situation.⁶ The clinician must carefully assess, for

example, whether a family's request to with-hold information from the patient is based on cultural norms or is a result of family conflict. While it is usually optimal for the palliative care practitioner to encourage open communication among family members and to avoid involvement in keeping secrets, the practitioner should honour patients' requests for privacy and confidentiality when they do not risk jeopardising anyone's well-being.⁶ Unresolved family conflict will hinder establishing shared goals of care as well as discussions about the patient's impending death.

In general, healthcare professionals must be careful not to distance themselves in reaction to difficult situations.¹⁹ Back and Arnold¹² offer practical strategies for providers, which included: (i) active listening to focus fully on the other individual's concerns and demonstrate understanding; (ii) self-disclosure of one's feelings without blaming others; (iii) explaining what aspects of the situation are most concerning; (iv) empathising and demonstrating understanding of the other individual's feelings; (v) reframing the conflict as a mutual problem that can be resolved in collaboration with one another; and (vi) brainstorming strategies for resolving the conflict while remaining open to all ideas initially (*i.e.* without critiquing).

Few family interventions designed to address the needs of families coping with the end-stages of terminal illness have been empirically validated. FFGT is based on empirical research demonstrating the relationship between family functioning and poorer health outcomes,^{15,31} and has demonstrated efficacy in a large, randomised controlled trial.³⁸ As a preventive intervention, FFGT targets families who exhibit some restriction of functioning during palliative care that potentially places them at risk for difficulties before and after the patient's death.^{5,33,39} There are typically three or four sessions that include the patient prior to death, with continuation of family support extending to bereavement.

Kissane⁵ outlined specific therapist interventions used in FFGT. These include: (i) developing a strong therapeutic alliance, which may serve as a model of a cohesive relationship for family members; (ii) using praise to re-inforce the use of the family's strengths; (iii) collaboratively negotiating a contract outlining which family concerns warrant attention; and (iv) assisting the family to take responsibility for problem-solving their concerns. Essential techniques to achieve focus in short-term therapy include efficiently prioritising and summarising.⁵ Use of circular and reflexive questioning provokes discussion, insight, and therapeutic change.³⁴ Such approaches promote open communication, including the sharing of grief, and enhance cohesion and expressiveness within the family system.⁵ As therapy progresses, clinicians can refine their conceptualisations of the family through sharing process notes in peer supervision, where they may reflect on what transgenerational patterns of relating exist, better recognise family strengths, and make sense of any countertransference they are experiencing.⁵

FFGT therapists aim to identify previous patterns of relating, particularly during times of stress and other losses.^{33,39} These are then linked with current interaction patterns. Ultimately, the therapist may capitalise on families' strengths and increase their capacity for coping with the stress of the patient's progressing disease and impending death. Designed as a brief intervention, FFGT does not aspire to resolve long-standing family issues or any characterological problems of individual family members.⁵

The sharing of grief about the many losses is a poignant feature that mobilises support. The family is prepared for the course of illness, for the dying process, and for life without the patient after the death. When anger erupts, it is important for clinicians to help the family understand its origins. Therapists strive to understand the family's general ideology, and family members are encouraged to respect differences among themselves.⁵ Pointing out the

way in which diverse perspectives can strengthen the family may be valuable.⁵ As cohesiveness increases, therapists reinforce its benefits to the family.

Other approaches that have been used with families dealing with chronic illnesses have applicability in palliative care. A family meeting can be used to provide education about what to expect as disease progresses, how to manage death at home or in the hospital or hospice, how to discuss death and to say good-bye, and the multiple demands of care-giving, as well as its positive aspects.²¹ In fact, in a randomised controlled trial, Hudson *et al.*⁴⁰ found that family care-givers of patients dying at home who received a psycho-educational intervention reported a significantly more rewarding care-giving experience than those who did not. Family meetings can also aid in the assessment of problematic issues and help in efforts to resolve conflict. Table 1 presents an outline of the strategies recommended by the Comskil Laboratory at Memorial Sloan-Kettering Cancer Center for palliative care providers to use when conducting family meetings.²¹ Wein¹⁴ recommends that patients provide consent for such meetings, regardless of whether or not they are present, and that no more than two or three staff members attend such meetings so that families are not overwhelmed.

Multiple-family groups (MFGs) may also be useful, as they allow families to come together, receive psycho-education, and have the opportunity to share and to connect with other families. MFGs capitalise on families' experiences coping with adverse circumstances.³⁵ Including patients in these groups is especially powerful,³⁵ although it may be quite challenging when the patient is imminently dying.⁴¹

Treatment decision-making

One of the greatest challenges that families face is making decisions for the incapacitated patient. Patient autonomy is highly valued in Western cultures.¹⁴ Cognitively impaired, sedated, or comatose patients may be unable to express their preferences for resuscitation or withdrawal of life support. Physicians have indicated that one of the most significant barriers to communication with families about end-of-life care preferences and treatment plans, including the withdrawal of life support, is family conflict.⁴² Tilden and colleagues¹⁷ found that families experienced increased burden when these discussions did not occur or were postponed, if withdrawal of life support was delayed after being scheduled, when a single member is responsible for decision-making, or when the patient's death is perceived as a failure.

It follows that the best way to prevent conflict is to discuss the transition to palliative care and advanced care planning as early on in the course of treatment of advanced disease as possible. These conversations should take place gradually. Patients and families can be consulted periodically to ensure mutual agreement about the goals of care.¹⁷ When healthcare providers disagree with the family on a treatment decision, Back and Arnold¹² suggest that clinicians refrain from attempting to demonstrate that their stance on the matter is 'correct'. The development of a collaborative working relationship with the family based on shared interest in the patient's well-being tends to produce a successful outcome.

Cultural differences

The impact of culture on the manifestation and resolution of conflict is pervasive, ranging from how 'family' is structured and defined to patterns of communication. Culture impacts the family's response to medical illness and the extent to which the family is involved in patient care. For example, Kawaga-Singer and Nguyen²⁰ describe how Asian families may appear to infantilise patients to Westerners. Family-based decision-making is dominant in many Asian cultures. Conflict within the family can impede them making decisions quickly

and can lead to hostility among members.⁶ If members of the family oppose discussing disease progression and palliative care, the situation may become difficult. Cultural Differences found that one-third of family members were resistant to being open about disease progression, resulting in patients being prevented from consenting to treatment plans. It becomes hard to define the goals of a palliative approach.

In addition, culture plays a role in how families express their distress (*e.g.* level of somatisation) and the extent to which they accept mental health services.²⁰ It is important to respect the family's culturally-influenced coping style, as attempting modifications in a family system that is not rooted in the same belief systems can be challenging, particularly when members are immigrants with varying degrees of acculturation. Religious practices may be particularly influential in the family's beliefs about the meaning of end-of-life care, including the withdrawal of life support. Understanding the family's religious context is critical to assessing and intervening in conflicts with providers and among family members.⁴³

Special-needs populations

Some families experiencing conflict have special needs that require extra attention and care by the palliative care team.²¹ Families with young children losing a parent may require additional psychosocial services. The situation may be complicated if a single parent is dying, leaving the children orphaned. Elderly parents who are dying while providing care for a physically handicapped or mentally ill child, or patients isolated through migration, or disenfranchised from the support of other relatives (*e.g.* a patient dying of AIDS whose family has difficulty accepting the illness) may also require special care. In these cases, a thorough assessment of the family's story and needs can facilitate the appropriate delegation of resources and use of referrals.²¹

When crises emerge

New life events can emerge that cause additional disruption within the family. Observing how the family copes with these events, which may include job changes or losses, financial strain, couples' distress, pregnancies, and substance abuse problems, may provide the clinician with additional insight into the family's strengths.⁵ These should be highlighted while making efforts to maintain focus on the family unit rather than the member in crisis.⁵ Although patient or family crises often limit preparation of the family for the patient's death, they may also provide opportunities for new ways of relating that promote secure attachment and help transform insecure attachment styles.²³

Challenges in conflict management

While few would deny the need for effective family interventions, Hudson *et al.*⁴⁴ point out that there are several barriers to their successful implementation within palliative care settings, including care-givers feeling hostile, rejecting help or not obtaining support because of a fear of burdening healthcare providers, having difficulty concentrating or conspiring to remain silent about prognosis. Reasons for clinicians not appropriately managing conflict include a lack of time, interest, or confidence to negotiate the situation, or their belief that conflict is best avoided or suppressed in order to keep the peace.¹² The long-term negative repercussions of avoidance include decision-making difficulties during patient crises and, when executed in a functional matter, open communication tends to result in the best outcomes.¹²

Steinglass³⁵ provides some reasons that family conflict may be poorly managed, including professionals' lack of training in working with families, challenges with scheduling meetings between providers and family members, and the widely held belief that attention

should only be focused on the medically ill patient. Back and Arnold¹² propose that the most important pitfall to avoid in conflict management is engagement in pressured negotiations with patients or families while they are angry or upset. Escalation of negative emotions is the danger. Clinicians may wisely avoid becoming entangled in the problem and take a ‘time out’, allowing about 20 min to monitor their own emotional reactions and to develop strategies to negotiate the conflict.¹²

Some families are fractured by long-standing differences of opinion or entrenched arguments, have coalitions among their members, and may present challenges that seem impossible to circumvent. While it is difficult to do in practice, clinicians should give themselves permission in certain cases to acknowledge that it is ‘too hard’ to achieve optimal outcomes. The pull for homeostasis within families is strong, and so identifying a family member who is likely to be more co-operative, avoiding being drawn into petty conflicts, and setting realistic goals is fundamental clinical wisdom.

Conclusions

The stressors of palliative care, including management of practical assistance and treatment decisions for the patient, witnessing the patient’s suffering, and anticipating their death, result in disagreements between family members and healthcare providers. Applying a family-centred approach to assessment and intervention with efforts to focus on shared interests increases the likelihood of successful resolution of family strain and optimal care for the patient and all involved.

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Table 1
Strategies for conducting a family meeting in palliative care

- Planning and prior set-up to arrange the family meeting
- Welcome and orientation of the family to the goals of the family meeting
- Check that each family member understands the illness and the patient's prognosis
- Check for consensus about the current goals of care
- Identify family concerns about their management of key symptoms or care needs
- Clarify the family's view of what the future holds
- Clarify how family members are coping and feeling emotionally
- Identify family strengths and affirm their level of commitment and mutual support for each other
- Close the family meeting by final review of agreed goals of care and future plans

Adapted from Kissane *et al.*²¹