Conflict mediation: proposed solutions to deal with cases of violence against older people

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Abstract

Objective: To describe the reasons for violence against older people and the solutions proposed for conflict mediation in an outpatient clinic specialized in geriatrics and gerontology in the Federal District, Brazil, between 2008 and 2018. *Method*: A retrospective, documentary, descriptive study with a quantitative approach developed with the analysis of information obtained in the unit's minutes books via the records of conflict mediation meetings in cases of violence against older people. The collection covered the reasons for violence against older people and the solutions proposed for conflict mediation. *Result:* We analyzed 111 cases. The main reasons for the violence were main caregiver burden (77.4%), children thinking that their older parents were able to take care of themselves (27%), resentment of children towards their older parents (24.3%), and being unaware of the older person's disease (14.4%). The main solutions proposed were regular follow-up with a doctor (82.8%), social worker and/or psychologist (58.5%), the commitment of all children in sharing care and expenses of their older parents (52.2%), introducing the older person to social activities in the community (27%), and hiring a formal caregiver (24.3%). *Conclusion:* The caregiver burden was the main cause for conflict found, and the proposals identified were related to the greater need for health care for the older person and their caregiver. In this regard, the importance of a multidisciplinary team available in situations of violence was perceived. Conflict mediation made it possible to establish real and targeted strategies to achieve results in cases of violence.

Keywords: Elder Abuse. Violence. Negotiating. Caregivers.

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INTRODUCTION

The aging of the population poses challenges to the public healthcare service, as new demands and specific needs of this population group are increasingly present in the services[1]. Aging involves a gradual loss of functionality, which may lead to cognitive decline, greater global dependence, and many times the onset of chronic diseases. Besides all these common characteristics, this age group is also vulnerable to the phenomenon of violence[2].

Violence against older people is defined by the World Health Organization (WHO)[3]as a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to the victim and it can be classified as physical, sexual, psychological, and emotional abuse; financial and material abuse; abandonment; neglect.[4].

In Brazil, 28% of households have at least one older person, and the main aggressors are children and spouses[5,6]. The structure of the contemporary family with the insertion of women in the labor market, fewer children, and more divorces contribute to the marginalization of the older person and the occurrence of violence[2,5]. On the other hand, the family represents the older person's main support network, being a concrete reference according to the Brazilian legislation[7].

Given the above, the complexity of the phenomenon of violence has demanded progress regarding stereotyped, fragmented, and ineffective health care models. There is the need for team approaches with intersectoral and articulated work to allow the detection and notification of violence, besides proper attention and interdisciplinary care to interrupt or minimize conflicting situations[8,9].

Conflict mediation is a non-legal, effective technique, although still incipient in Brazil. It is based on meetings with the participation of family members and other people involved in taking care of the older person and may be conducted by health professionals from different areas once they are trained for that. The approach aims to identify the roles of each individual in the older person's support network, outline the difficulties pointed out by the participants, and articulate care commitments[6,10].

The mediation method is based on identifying the motivations causing violence so that with the dialogue and cooperation between the parties possible means of resolving the conflict are outlined in order not only to suppress violent situations against older people, but to prevent new injuries, minimize risks, and make positive agreements[6,7,10].

The analysis of data obtained by conflict mediation offers guidance for further studies and applicability in health care practice. It is also noted that the scientific productions about conflict mediation and its results are incipient. Thus, the present study aims to describe the reasons for violence against older people and the solutions proposed in conflict mediation meetings between 2008 and 2018 in an outpatient clinic specialized in geriatrics and gerontology in the Federal District (DF), Brazil.

METHOD

Retrospective, documentary-descriptive study with a quantitative approach developed from the analysis of information collected from minute-books with the reports on mediation meetings in cases of violence against older people. The appointments were between 2008 and 2018 in an outpatient clinic specialized in geriatric and gerontological health in the Federal District (DF), Brazil. This outpatient clinic has an interdisciplinary team specialized in older people's care, being the only one with integrated outpatient care referenced to this population in the city.

The cases received and referred to the unit comprised specific situations, such as unaccompanied dependent older people, older people, and caregivers without knowledge on the health condition of the older person, older people with significant cognitive decline in a situation of neglect, older people who reported financial exploitation by family members or other caregivers, abandoned older people, older people suspected of physical and psychological

violence, among others. These situations were reported by the older person, a family member, acquaintances, the older person's formal caregiver, or anyone from the community including a healthcare professional during the appointment.

Any member of the healthcare team could send a case report to the social service recording the situation of violence or suspected violence. Family meetings took place once a week on a pre-set date after the family members and other people involved in elderly care were invited by the social worker to come to the healthcare unit.

The conflict mediators (social worker, nurse, psychologist, or another professional from the team) conducted the mediation meeting whenever at least two healthcare professionals were present. The minutes were drawn up in the open field, usually by the social worker who in turn also carried out the notification of violence and the follow-up of cases and results achieved.

The inclusion criteria used were cases of older people aged 60 years and over treated at the specialized unit and registered in the minutes of conflict mediation meetings.

The meeting minutes recorded between 2008 and 2018 were independently analyzed by three properly trained researchers in the period from June 2018 to January 2019. Open information regarding the reasons and proposed solutions were collected. The divergences that occurred due to the limitations found in the records were jointly discussed among the six researchers. Data were analyzed based on the synthesis of all meetings held for each case of violence, with new information and results found later on being added when a second meeting took place.

There were 143 cases in the minute books with one or more family meetings per case, excluding situations in which there was no violence and/or treatment of individuals under 60 years of age, totaling 111 cases in the analyzed sample.

For data analysis, a descriptive statistical analysis was performed accounting for data on the reasons for violence and the solutions proposed (agreed) for solving cases of violence against older people, and two tables were prepared with the absolute and relative frequencies of answers.

The present study was approved by the Ethics Committee of Fundação de Ensino e Pesquisa em Ciências da Saúde (FEPECS) under Opinion No. 1.798.579, of October 29, 2016, with an addendum to continue the study in 2017 and 2018. It was also developed following Resolutions No. 466/2012 and No. 510/2016 of Conselho Nacional de Saúde (the Brazilian National Health Council).

RESULTS

We analyzed 111 cases reported in the minute book. During the 10 years of reports, we observed a decrease in the number of violence occurrences identified in the unit, as shown in Figure 1. Note that between 2015 to 2018 there were periods of unavailability of a qualified professional (social worker), consequently reducing the number of conflict mediation meetings during this period.

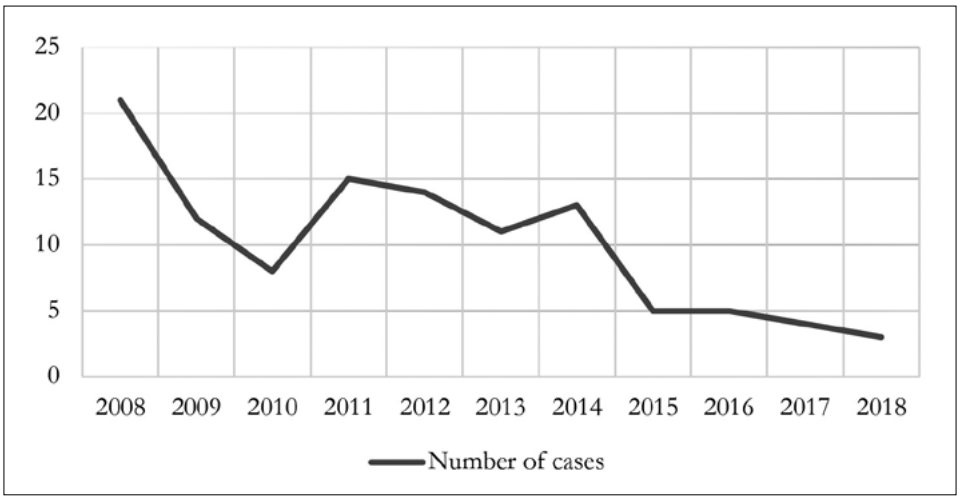

Figure 1. Number of cases of violence reported between 2008 and 2018 in a specialized geriatrics and gerontology outpatient clinic (N=111). Federal District, DF, Brazil (2008-2018).

Regarding the older people who were victims of violence, 72% were women, the predominant age groups were from 81 to 90 years old (45%) and 71 to 80 years old (39%), and 5% were nonagenarians. Most older people lived in their own homes with an income of one minimum wage (46%). Regarding the comorbidities identified, 54% of older people had dementia, 31% had systemic arterial hypertension, and 13% had diabetes mellitus. Of the older people with dementia, 32% of the individuals involved in care were unaware of the disease symptoms.

Children were the main aggressors identified (72%), with 62% of the aggressors being male and 38% female. Regarding the aggressor's age group, there was a predominance between 51 to 60 years (37%) and between 41 to 50 years old (30%).

Regarding the type of violence suffered, there was a higher prevalence of negligence (56%), followed by psychological violence (29%), physical violence (8%), and financial abuse (6%). Neglect associated with abandonment represented 21% of the cases.

As shown in table 1, the main caregiver's burden was identified as the most common reason (77.4%). Another frequent finding was the lack of knowledge on the functional capacity of the older person, leading to negligence for believing that they would carry out their activities without supervision or intervention, which represented 27% of the sample.

Data obtained in cases of violence by children showed that 24% resented the older person or the fragility of the affective tie built during the life of both, thus resulting in frequent conflict situations and violent acts. Another 27% believed that their older parents were able to carry out their activities alone.

At the same time, 6.3% of caregivers did not provide continuous care to the older person when they needed help and care 24 hours a day due to their health condition.

Regarding the older people with dementia, it was observed that in 14.4% of the cases caregivers were unaware of the older person's diagnosis or had no understanding about the disease, common reactions, and how to behave when facing situations resulting from this situation.

Among the motivations related to the main caregiver, 6.3% had depression and 4.5% were addicted to alcohol.

Regarding the solutions proposed during the conflict mediation meeting, it can be seen in Table 2 that there was more than one solution agreed upon in the mediation for each case analyzed.

For the most part (92 cases), regular follow-up with the medical team available at the healthcare unit was recommended. More than half of the cases analyzed also required referral and follow-up by the social assistance and psychology service (58.6%).

Of the 111 cases, 38 set a cooperation agreement between the children during a meeting with the team and family members. In 27 cases, it was decided to hire a formal caregiver. The inclusion of the older person in community activities represented 27% of the solutions proposed to the cases.

Table 1. Reasons for violence against the older person in the specialized geriatric and gerontology outpatient clinic in the Federal District, DF, Brazil (2008-2018).

Reasons for violence against the older person	Number of Cases (%)
Primary caregiver burden.	86 (77.4%)
Children believed that older parents were capable of taking care of themselves.	30 (27%)
Resentment of children towards the older person or fragility of the affective tie.	27 (24.3%)
Unaware of the older person's disease (dementia cases).	16 (14.4%)
Caregiver lack of interest in the supervision of the older person's medication and/or neglect of chronic diseases.	15 (13.5%)
Caregiver's behavior changes.	8 (7.2%)
Main caregiver with depression.	7 (6.3%)
Unaware of the need for continuous care (24h/day)	7 (6.3%)
Main caregiver addicted to alcohol.	5 (4.5%)

Source: Prepared by the authors.

Table 2. Solutions proposed by the conflict mediation in the specialized geriatric and gerontology outpatient clinic in the Federal District, DF, Brazil (2008-2018).

Proposed solutions by the conflict mediation team	Number of cases (%)
Regular follow-up with a doctor (family doctor or geriatrician) regarding the progression of diseases, especially dementia, and the control of chronic diseases.	92 (82.8%)
Regular monitoring of the older person with a social worker and/or psychologist.	65 (58.5%)
Commitment of all children to share the care and/or expenses of their older parents.	58 (52.2%)
Older person's introduction in community social activities.	30 (27%)
Hiring a formal caregiver.	27 (24.3%)

Source: Prepared by the authors.

The caregiver was referred to a healthcare service that met their demand (psychologist, psychiatrist, and physician) in 12 cases in which severe depression and alcoholism were detected.

In 18 cases, the older person with dementia was included in cognitive therapy groups led by an occupational therapist and a nurse, in addition to the practice of manual activities (handicraft) available in the specialized outpatient clinic.

DISCUSSION

The motivations related to the violence process against the older person vary, and it is possible to observe the presence of more than one reason mentioned in several cases in the present study. Among them, the burden imposed on caregivers during the process stands out, reported in 77.4% of cases. Prolonged emotional stress is related to the caregiving responsibility of only one individual who generally did not choose to play this role nor is properly trained for that[11].

The older person's high level of dependence for activities of daily living (ADL) and instrumental activities of daily living (IADL) comprises a higher risk for violence[12] and a higher rate of caregiver burden, which in turn is a triggering factor for care negligence of the person under care, with the omission of basic needs to the older person[11].

The impact generated by continuous care can be mitigated by sharing it with the other support networks of this older person, whether in family arrangements or psychoeducational support groups. It is known that the appropriate balance between the demand for care and the time offered for care can produce better results when this caregiver is duly prepared and trained[11].

The caregiver is represented in studies as a female relative with an average age of 53.9 years who lives in the same household as the older person[11,13]. Living in the same household favors violence[11], which in turn is disguised in the attempt to preserve ties or is justified by the feeling of guilt on the part of the older person. Sometimes violence goes unnoticed and is seen as a behavior pattern or interpersonal stress of the caregiver[13,14].

The resentments of the children towards the older person or fragility of the affective ties were also motivations found in the present study (27%). Other reasons presented in different studies involve financial issues, conflicts of interest between generations, and interdependence among those involved[12,15].

In this sense, conflict mediation is an essential resource for restoring relationships and reflecting the reality lived. A study on family mediation by Martins[7] addresses the current family as a social institution not having information and support to perform the task of caring. In this sense, a resolutive approach demands to look at the social context and the whole process in which the subjects are inserted[7].

Among other reasons for violence detected in the present study, 14.4% of the cases showed a lack of knowledge about dementia and its presentations. When analyzing risk factors for violence, the studies relate dementia to up to four times more violence against the older person[12,16].

Older people affected by dementia can act aggressively and generate a reciprocal violent act of the caregiver[12]. Knowledge of possible behavioral changes favors the caregiver's understanding and protects the vulnerable older person from harm and suffering. The healthcare professional duly trained for proper handling and management of the disease becomes indispensable[15].

A recent study about caregivers of older people with dementia found a prevalence of depression and panic syndrome in 8%[16]. The caregiver getting sick was also reported in the present study; depression was reported in 6.3% of the cases.

Caring for an individual requires biopsychosocial commitment, and studies show that the caregiver's quality of life directly interferes with the quality of care provided by them. Generally, healthcare professionals do not give due attention to the caregiver, who lacks social support. Positive interpersonal relationships and manifestations of

affection and love are examples of what others can offer to the caregiver to contribute to improving their quality of life[13,17].

When analyzing other caregiver-related factors contributing to a higher incidence of violence, Lino et al.[15] identified alcoholism as an important variable causing an increase of 3.8 times the risk of violent acts. Alcohol addiction can be identified when it generates social consequences from its consumption.

The offer of follow-up and treatment to this caregiver becomes mandatory to interrupt a habit that generates conflicts, distress in the relationships, and human suffering[18]. In the present study, the caregiver's medical and psychological follow-up was established as a proposed solution since there were five cases of alcohol addiction reported.

The challenge to identify the violence perpetrated in the family environment is sometimes disguised as a common relationship pattern. Despite this, we perceived the importance of continuous training of health professionals for sensitive and attentive listening of older people and caregivers in each appointment.

Regarding conflict mediation, it is possible to detect important social, financial, and emotional frailties in caregivers who lack professional and social support and have little or even no support and guidance to work.

A possible limitation in the study was regarding the low systematization of the questions for the record because the production of minutes did not aim to be a research instrument. Thus, some data from the mediation practice may not have been reported or were reported with inaccuracy. We suggest the development of semi-structured minutes so that no relevant information is lost.

CONCLUSION

The analysis of the results obtained by conflict mediation shows the need for interventions directed to the main caregiver, such as actions to promote physical and mental health since burden was a frequent finding related to the cases of depression and alcohol addiction found. Regarding the lack of knowledge about the older person's disease, we emphasize the importance of training the people involved in care to prevent the forms of violence resulting from negligence. The availability of a multidisciplinary team becomes essential regarding the care of the old person who is a victim of violence since among the main solutions proposed was a great demand for treatment with a psychologist, social worker, and geriatric physician available in the unit.

Violence towards the older person corresponds to a multifactorial phenomenon, and the analysis of motivations allows entities and healthcare professionals to draw care plans to prevent situations generating violence, and enabling real and plausible possibilities of resolution according to the situation presented. We observed the great need to create new initiatives and health methodologies aimed at the older public since comprehensive care focused on the needs of each individual allows better results.

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