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Eldercaring Conflict Checklist (ECC): Development, Pilot, and Initial Validation of Scale

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Abstract

Unresolved family conflicts regarding caring for older adults can devastate their overall health, well-being, and the quality of care from their support networks. To better understand conflict in the context of caring for older populations, this study developed and piloted a new screening tool, the Eldercaring Conflict Checklist (ECC). The ECC was developed to help professionals provide targeted responses and interventions. The ECC is based on a literature review focusing on the factors associated with the typologies of family conflict in caring for older populations. A diverse sample of 157 professionals serving older populations in conflict answered an online survey using a case study vignette and the ECC. The ECC's validity, reliability, and factor structure were analyzed and explored quantitatively and by coding emerging themes in open-ended qualitative questions in the survey. The respondents reported that the ECC is comprehensive and useful, indicating its value as an intake screening tool and helpful for reliably and thoroughly assessing and measuring conflict within older adult family relations. Results show that the ECC demonstrates very high internal validity and model fit indices for the entire ECC, and each of the eight factors showed promising results. Implications are discussed regarding working with families within eldercaring coordination and elder mediation.

Keywords Conflict · Screening Tool · Dispute Resolution · Eldercaring Coordination, Scale · Validation · Psychometrics · Elders

Eldercaring coordination is a dispute resolution option that was specifically developed for families experiencing high conflict regarding the care and safety of an older adult (60 years old and above based on a majority of legal constructs in the U.S., Canada, and Australia). The eldercaring coordination process was created to help manage high-conflict family dynamics with older populations (Fieldstone & Bronson, 2018). Families in high conflict need a process and services that meet their specific needs and characteristics (Saini, 2020). Eldercaring coordination focuses on enhancing the quality of life of older adults by shielding them from family conflict,

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improving care, and enhancing decision-making that is attuned to the older adult's voice and preferences. Why is this important? Family conflict can deleteriously affect the aging person's health and quality of life (Wilson et al., 2021; Perissinotto et al., 2012; Kiecolt-Glaser & Newton, 2011). Conflict contributes to the number of transitions the older person may face, requiring alternate levels of care and even life expectancy (Merla et al., 2018; Levy et al., 2002).

Conflict interferes with the safety of older adults, who face an increased risk of isolation, abuse, and exploitation (Sapin et al., 2016). According to the U.S. National Council on Aging, family members are the perpetrators in approximately two-thirds of elder abuse incidents, with only one in 24 cases reported. An independent study of eldercaring coordination by Teaster and Dolbin-MacNab (2019) of Virginia Tech revealed that eldercaring coordinators identified multiple cases of abuse in over 60% of their cases. Eldercaring coordinators provide families with the necessary tools and strategies to move from blame and personal agendas, which may lead to unsafe conditions, and toward addressing the older adult's needs and interests.

As communication becomes more effective and conflict decreases in the eldercaring coordination process, older adults, their family members, and other participants (e.g., non-family care providers and involved professionals) begin to focus more productively on issues related to the needs and safety of the older adult and work collaboratively to develop their support network, including professionals that provide legal and financial advice, social and medical care, and additional guidance (Dobin-MacNab & Teaster, 2019).

Complex family dynamics are typical of eldercaring coordination cases. It is hence essential for eldercaring coordinators to have effective screening tools to help them assess the situation and identify the most suitable interventions in the context of the eldercaring coordination process. The Eldercaring Conflict Checklist (ECC) intends to provide Eldercaring Coordinators (ECs) and other professionals with a reliable and valid screening tool for the nature, frequency, severity, and typologies of conflict within older populations needing care and their families. Identifying the typology of conflict will help professionals determine the most relevant interventions to reduce conflict, increase focus on the needs of an older adult, and enhance communication and decision-making skills regarding the provision of care and the safety of the older adult. While developed initially with eldercaring coordinators in mind, this tool can be applied by any professional working with families in conflict to improve the quality of life of older adults. Given the age and, at times, increasing frailty of an older family member, professionals need to identify their most productive course of action.

Traditional Forms of Conflict Resolution and Eldercaring Coordination

Traditionally, families in conflict concerning care for an older adult have turned to court to resolve their eldercaring-related disputes. The court process is adversarial in nature and is in danger of encouraging a win-lose frame mentality, adversely stirring family members to focus on the past, blame, and degradation rather than acknowledging and incorporating the strengths of their family members and family dynamic in

a solution-focused process (Menkel-Meadow, 2001). It is well understood that exposure to and interaction with aggravation and conflict can harm an individual's well-being (Offer, 2020)**.** Recently, in recognition of the limitations of the litigation process, elder mediation has come to the forefront as a possible alternative for families struggling with unresolved issues (Martin, 2015). Unfortunately, mediation runs the risk of becoming a forum for venting frustration, especially when the mediation process lacks tools and processes for redirecting family members from searching for punishment and retribution to reaching a resolution (Fieldstone & Bronson, 2015). Eldercaring coordination addresses these limitations and caters to the unique needs of families in high conflict by helping them learn how to focus on the older adult rather than animosity toward each other.

Eldercaring Relationships

As people age, positive, deep, and meaningful social connections are essential for their emotional well-being, health, cognitive functioning, and survival (Bloche, 2005; Umberson & Montez, 2010). Hence, older adults often prefer receiving care from family members rather than community programs and/or non-family care providers (Cantor, 1989). However, in cases where family relationships are consumed by conflict, some of the family members may disengage from the older adult to avoid such discordant relationships, heightening the older adult's sense of loneliness and isolation and significantly disrupting the care provided to them (Kayashima & Braun, 2001; Offer, 2020). Conflict also interferes with a collaborative team approach to addressing older adults and their family's needs (Kramer & Yonker, 2011). In 2018, the Wellcare Health Plan Provider acknowledged family conflict as a health threat for older adults, given that ongoing conflict places undue stress on a family and can delay needed medical treatment and therapies, adversely impacting the health of older adult and their families (Wellcare Health Plan, 2018).

Research and case law show that diverging views about caregiving between the older adult and family members, or just between the family members themselves, may intensify conflict, resulting in increased risk for the older adult (Brank & Wylie, 2021). Intergenerational relationships can vacillate between producing negative and positive influences, known as *ambivalence,* and affect the well-being of each family member (Connidis, 2015; Fingerman et al., 2008; Girardin et al., 2018; Kyeremeh & Schafer, 2024; Offer, & Fischer, 2018). It is crucial to recognize the importance of the family system as a whole in the older adult's care and the importance of understanding the family dynamics to enhance the care effectively and sustainably for the older adult (Lieberman & Fisher, 1999).

Caregiving, Conflict, and Eldercaring Dynamics

Repercussions of family conflict have wide-ranging effects. As older adults' health declines, extended time in hospitals and rehabilitation centers is more likely induced by increased fragility and falls. (Callahan et al. 2015; Sterling,

et al., 2001). Relocations can be stressful and may be accompanied by anxiety. Transitions between healthcare settings are a particular risk period for older adults' safety and quality of care, with one in five older patients experiencing adverse events during the transition from hospital to home (Naylor & Keating, 2008). For example, research shows that increased stress among adult siblings and between adult siblings and their spouses were significantly correlated with families' intention to move the older adult to a nursing home (Savundranayagem et al., 2011).

Family dissension, including differing views about the older adult's preferences and conflicting goals set by different family members, intensifies caregiver strain and may adversely impact the caregiver's own health (Barnett, 2015; Werner et al., 2012). Additional complications may occur when a family member is experiencing what they perceive as parental rejection or animosity (Kong & Moorman, 2015; Whitbeck et al., 1994). Stressors in caregiving may lead to depression, apprehension about depleting financial resources, time spent away from home, lack of sleep, and greater discordance in family relationships (Bookwala, 2009; Schulz et al., 1990; Strawbridge et al., 1997). These pressures may affect decision-making on a day-to-day basis (Elliott et al., 2007; Parks et al., 2011). Further complications arise when efficiency considerations and safety concerns clash with older adults' desire to maintain their autonomy. Conflicting goals and the need to manage behaviors become the center of focus at the expense of proper attention to the older adult's needs and care (Elliott et al., 2007).

An Ecological Framework for Eldercaring Conflict

Existing measures of conflict within families concerning the care of an older adult have been developed based on various theoretical frameworks, locating the conflict at the intersection of several eldercaring dynamics (Widmer et al., 2018). Some measures of eldercaring conflict are centered on the individual caregiver and their role (Lieberman & Fisher, 1999; Lowerstein, 2007; Rahman, 1995). These tend to overemphasize problems relating to the personality mismatch between the caregiver and the older adult and/or other family members' mental health concerns and other idiosyncratic characteristics of the individuals involved. Other measures tend to overemphasize structures and systems exogenous to the family, such as the courts, the healthcare system, or social services, as ultimate causes of eldercaring family conflict (Dew & Yorgason, 2010; Schulz & Martire, 2004).

To better define, assess, and measure the presence and severity of conflict and identify the various factors involved, we have developed the ECC using an ecological transactional model (Sameroff & Mackenzie, 2003). Mapped onto an ecological transactional model (see figure 1), eldercaring conflict is understood as an emergent whole, arising from multiple interactions between the older adult, the

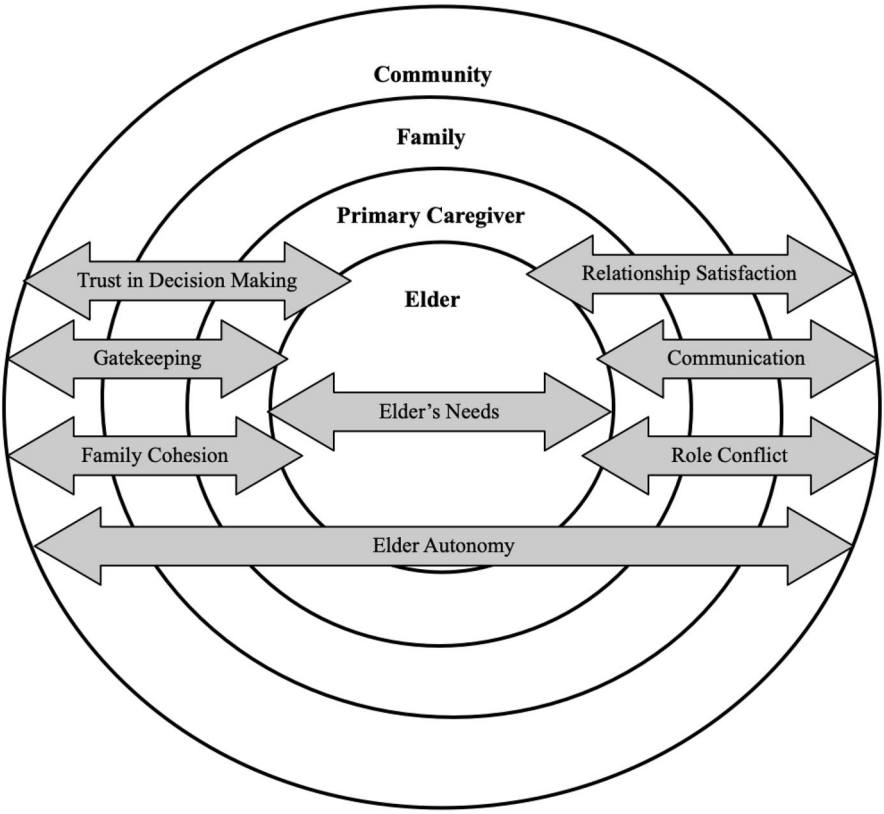

Fig. 1 Ecological Framework for Understanding Eldercaring Conflict

caregiving relatives, the family, the community, and service providers, organizations, and institutions (Saini, 2020).

The ecological transactional framework for eldercaring conflicts emphasizes the interactional nature of the conflict. The conflict is understood as *sedimented*, a complex accumulation of the relationships between the older adult and the family member across time (i.e., previous conflicts and ongoing conflicts). At the same time, the conflict is viewed within context, conditioned and constrained by the various strains and opportunities created and qualified by larger system-level factors (e.g., the pressures placed on families where there is a lack of affordable housing options for older adults) (Lowenstein, 2002).

At the individual level of analysis (the ontogenic system: biophysical, emotional, behavioral, cognitive), some individual indicators leading to conflict include lower levels of education, cognitive capacities, caregiver stress, guilt and shame over being a burden, individuals' poor health, poor decision making,

older adult disabilities, functional limitations, history of maladaptive coping strategies, sleep disturbances, role-related satisfaction, acceptance of life stages and fear of death (Ferring et al., 2009; Kramer et al., 2010; Lowenstein, 2002; Schulz & Sherwood, 2008; Scott et al., 2002; Stephens et al., 2001). There may also be pre-existing mental health problems influencing the conflict.

At the interpersonal level (the microsystem: parent-child, family, friends, kin, other members of social networks), conflict indicators include parent-child relationships, prior family conflict, family competition for control, family communication patterns and ability to discuss problems, dependency on younger family members for care (e.g. feeding, medication, etc.), sibling rivalries, the distance between family members, caregivers in a dual role, time spent providing care, family cohesion and cracks in solidarity, and incidents of perceived illegitimate demands (Halpern, 1994; Peisah et al., 2006; Rahman, 1993; Scharlach et al., 2006; Szinovacz, 2003; Usita & Du Bois, 2005; Zhang, & Lin, 2009). While conflict produces risks for numerous maladaptive outcomes in the generation involved in providing care and making decisions about the eldercaring, the effects of prior and ongoing conflict are even greater in the next generation, possibly culminating in deficient interpersonal skills, weaker social supports, and inadequate coping resources (Rothenberg et al., 2017).

At the organizational level (the exosystem), factors include entrenched litigation, healthcare settings, institutions, communities, factions among professionals, overlapping or competing services, satisfaction with professional or trust of professional support, and quality of professional care (Ayalon & Roziner, 2016; Beane, 2002; Hasson, & Arnetz, 2008). Finally, at the societal level (the macrosystem), conflict can be influenced by different views and cultural values about the care of the older adult, conflicts over religion and its intersection with eldercaring issues, societal lack of priorities for older adult care issues, such as inadequate healthcare services and insufficient funding for respite and support (Antonsson et al., 2012).

A multifaceted definition of conflict, therefore, should include an assessment of the variety of factors that may influence the presence of conflict, including those at each level of analysis. For example, when assessing for eldercaring conflict, it is important to consider the individual factors that may be escalating the conflict (i.e., overwhelmed with responsibilities, mental health concerns, feelings of isolation), the interpersonal factors (i.e., previous parent-child conflicts, sibling conflicts), the organizational factors (i.e., the lack of affordable housing for the older adult, the quality of care received by local health care facilities) and the larger societal factors (i.e., the restrictions placed on caregivers due to work-related biases towards time spent off work to care for an older parent). It is often the combination of the various factors that transform a conflict into an impasse within the family. So, an appreciation and awareness of these various influences can assist eldercaring coordinators in being more responsive to the various needs of the families rather than focusing on one aspect of the conflict (Saini, 2020).

Targeting Intervention

Conflict in families caring for an older adult may affect all of the generations in the family and have multi-generational and transgenerational effects - breeding risk factors for future health conditions for even the youngest family members. Assessing and better understanding eldercaring conflicts within the family system is essential to provide effective intervention. Care and decision-making for older adults have improved for families who adopt and utilize solution-focused decision-making styles and positive conflict-resolution skills (Lieberman & Fisher, 1999). Eldercaring coordination allows families to liberate themselves from the tumultuous ties that bind them, moving from past to present and building a new framework for their interactions to diffuse the conflict and focus on the older adult's needs and wishes over the duration of critical transition. Identifying conflict typology and the domains around which conflicts arise may assist eldercaring coordinators and other professionals in identifying the interventions that best address the specific issues experienced by each family. Measuring intergenerational solidarity may provide the eldercaring coordinator insight into some of the current underlying dynamics (Silverstein & Bengtson, 1997), while latent classes of intergenerational relations may provide insight into engagement patterns and feelings of emotional closeness (Bengtson & Roberts, 1991). Yet neither of these constitutes a standardized holistic approach to gathering information across all relevant domains. The ECC provides an evidence-informed screening tool suitable for initial screening during intake, for monitoring or reassessing at interim periods, and when services are terminated to evaluate the effectiveness of the intervention as indicated by the family's improvement in providing for the older adult's needs.

Purpose

There needs to be a reliable screening or assessment tool to help eldercaring coordinators identify the various sources of conflict, the levels of conflict, and how conflict manifests itself within eldercaring relationships. A validated tool is needed to help eldercaring coordinators differentiate between levels of conflict to target services and supports in a timely and efficient way. Such a tool is essential to support early intervention and prevention of conflict within eldercaring families to identify the various sources of conflict and to ensure services offered to families best address their unique needs. This tool is also needed to appropriately triage families by shifting less severe cases away from eldercaring coordination and towards elder mediation or other services, thereby helping to make family justice services more efficient and responsive to the needs of older adults and their families.

Methods

This study utilized a case-vignette rating electronic survey as the data collection method. The purpose of this method was to invite participants to read a case study

and then rate the case based on the ECC. The survey also collected open-ended responses from participants, allowing for an in-depth analysis of the participant's views on the newly developed tool. Participants were eldercaring coordinators and others affiliated with or assisting the Elder Justice Initiative on Eldercaring Coordination by providing their views and experience regarding eldercaring conflicts.

The electronic survey was created using SurveyMonkey software. It consisted of a case study vignette, the ECC, and a few qualitative open questions regarding the participants' impressions of the ECC and possible concerns. The survey took approximately 20-30 minutes to complete, and respondents were not compensated for their participation since they were professionals in the field of eldercaring family conflict, examining a professional tool that is directly related to their practice. The research protocol was approved by the University of Toronto Ethics Board.

Participants

Respondents were recruited by sending email invitations to directors of organizations that assist with conflict resolution information and/or services to elders and their families, including Eldercaring Coordination Program Administrators, Office of Public and Private Guardians, and the Florida Chapter of the Association of Family and Conciliation Court. After data cleaning, the final sample consisted of 157 respondents, most of whom reported at least ten years of experience in eldercaring for family conflict. As detailed in the results section below, the sample was highly diverse regarding the professions represented, with a skewed gender composition (74% identified as women), which is consistent with the known over-representation of women among eldercaring family conflict professionals.

Measure

The Eldercaring Conflict Checklist (ECC) is based on a literature review identifying eight factors associated with conflict typologies within eldercaring dynamics. These factors include the older adult's needs, relationship, role conflict, trust, elder autonomy, family cohesion, communication, and gatekeeping. The ECC is a checklist consisting of 70 questions for differentiating both levels and types of conflict within eldercaring coordination. It is intended to aid the eldercaring coordinator and other professionals in selecting strategies and interventions to support the quality of life of the older adult.

Data analysis

The psychometric properties of the ECC scale and the eight subscales composing the measure were calculated based on the pilot sample. We calculated the internal consistency of each of the eight subscales and the ECC scale as a whole, expressing a Cronbach's alpha coefficient. Confirmatory factor analyses (CFA) (Maximum likelihood estimation) were conducted for each of the eight scales and the ECC as a whole. Confirmatory factor analyses were used to assess how well the scale's

measurement model captures the covariance between all the items composing each of the eight subscales or the ECC scale. Confirmatory factor analyses also estimated the regression coefficients for each item (or subscale) and the proportion of the variation of each item (or subscale) predicted by the model.

The results of CFA hence provide us with information about the scale and its composing subscales' construct validly – the extent to which the scale and composing subscales really measure what they were designed to measure. The models fit indices calculated and reported were, following Kline (2012): (1) a chi-square tests indicating the difference between observed and expected covariance metrics; (2) the root mean square error of approximation (RMSEA), which measures the discrepancy between the hypothesized model, with optimally chosen parameter estimates, and the sample covariance matrix; (3) the root mean square residual (RMR) indicating the square root of the discrepancy between the sample covariance matrix and the model covariance matrix;(4) the goodness of fit index (GFI) is a measure of fit between the hypothesized model and the observed covariance matrix; the normed fit index (NFI) analyzes the discrepancy between the chi-squared value of the hypothesized model and the chi-squared value of a null of baseline model in which all the variables are assumed to be uncorrelated; (5) comparative fit index (CFI) analyzes the model fit by examining the discrepancy between the data and the hypothesized model, while adjusting for the issues of sample size inherent in the chi-squared test of model fit.

The qualitative answers to the open questions were reviewed and coded separately by two of the authors. The resulting codes were compared, and discrepancies were reconciled. The codes were then collapsed to create higher-level themes that are presented with representative quotes below.

Results

Of the 157 respondents, 74% identified as women and 26% as men. The majority were older than 55 (77%). The primary professional practice areas included Guardians/Conservators (23%), Mediators (20%), Attorneys (17%), Mental Health Professionals (13%), Judges (6%), Parenting Coordinators (3%), Healthcare Providers (3%), Financial Advisors (1%), and others (14%). Most have worked in older adult issues for over 10ten years (62%), with 36% having over 20 years.

Internal Consistency of Full Scale and its Composing Subscales

The Cronbach's alpha coefficients for the ECC scale as a whole and its eight composing subscales are presented in Table 1. The ECC, as a whole, showed an excellent level of internal consistency (0.924). In contrast, the composing subscales showed a level of internal consistency that ranged from questionable (Trust in Decision-making: 0.536) to good (Gatekeeping: 0.827).

Table 1 Internal consistency of ECC total and subscales

	Cronbach's alpha coefficient
ECC	0.924
Elder's needs	0.757
Relationship satisfaction	0.630
Role Conflict	0.781
Trust in decision making	0.536
Elder autonomy	0.752
Family cohesion	0.747
Communication	0.679
Gatekeeping	0.827

Scale and Subscale Intercorrelations

The intercorrelations between the ECC scale as a whole and its eight subscales are presented in Table 2. Five subscales (role conflict, trust, elder autonomy, family cohesion, and gatekeeping) were strongly correlated with the ECC scales as a whole,

Table 2: Intercorrelations ECC and its composing 8 factors

		ECC	EN	RS	RC	Trust	EA	FC	Comm	GK
ECC	r	1	.532**	.457**	.851**	.742**	.906**	.742**	.064	.811**
	p-value		.000	.000	.000	.000	.000	.000	.576	.000
EN	r	.532**	1	.326**	.434**	.335**	.407**	.260*	-.052	.154
	p-value	.000		.002	.000	.001	.000	.014	.619	.148
RS	r	.457**	.326**	1	.278**	.120	.327**	.204	.283**	.154
	p-value	.000	.002		.008	.253	.002	.054	.006	.147
RC	r	.851**	.434**	.278**	1	.696**	.766**	.643**	-.203	.576**
	p-value	.000	.000	.008		.000	.000	.000	.052	.000
Trust	r	.742**	.335**	.120	.696**	1	.754**	.462**	-.311*	.444**
	p-value	.000	.001	.253	.000		.000	.000	.002	.000
EA	r	.906**	.407**	.327**	.766**	.754**	1	.557**	-.002	.647**
	p-value	.000	.000	.002	.000	.000		.000	.982	.000
FC	r	.742**	.260*	.204	.643**	.462**	.557**	1	.036	.478**
	p-value	.000	.014	.054	.000	.000	.000		.732	.000
Comm	r	.064	-.052	.283**	-.203	-311*	-.002	.036	1	.134
	p-value	.576	.619	.006	.052	.002	.982	.732		.204
GK	r	.811**	.154	.154	.576**	.444**	.647**	.478**	.134	1
	p-value	.000	.148	.147	.000	.000	.000	.000	.204	

EN Elder's needs, *RS* Relationship satisfaction; *RC* Role conflict, *EA* Elder Autonomy, *FC* Family cohesions, Comm Communication, *GK* Gatekeeping

r= Pearson Correlation; *p*-value = significance level (2-tailed); * < .05, ** < .001

with a Pearson correlation coefficient ranging between 0.742 (trust/family/cohesion) and 0.906 (Elder Autonomy). Elder autonomy was hence highly correlated with the overall scale, indicating the central role of elder autonomy in the overall construct of eldercaring conflict. Communication was not significantly correlated with the ECC scale as a whole or with any of the subscales, except for a significant albeit weak correlation with Relationship Satisfaction (0.283) and a weak negative correlation (-0.311) with the subscale of Trust.

Factor Structure

The confirmatory factor analysis of the measurement model underlying the ECC scale is presented in Figs. 1 and 2. Models fit indices for the ECC measurement model and as a whole, and the eight composing subscales ranged from excellent

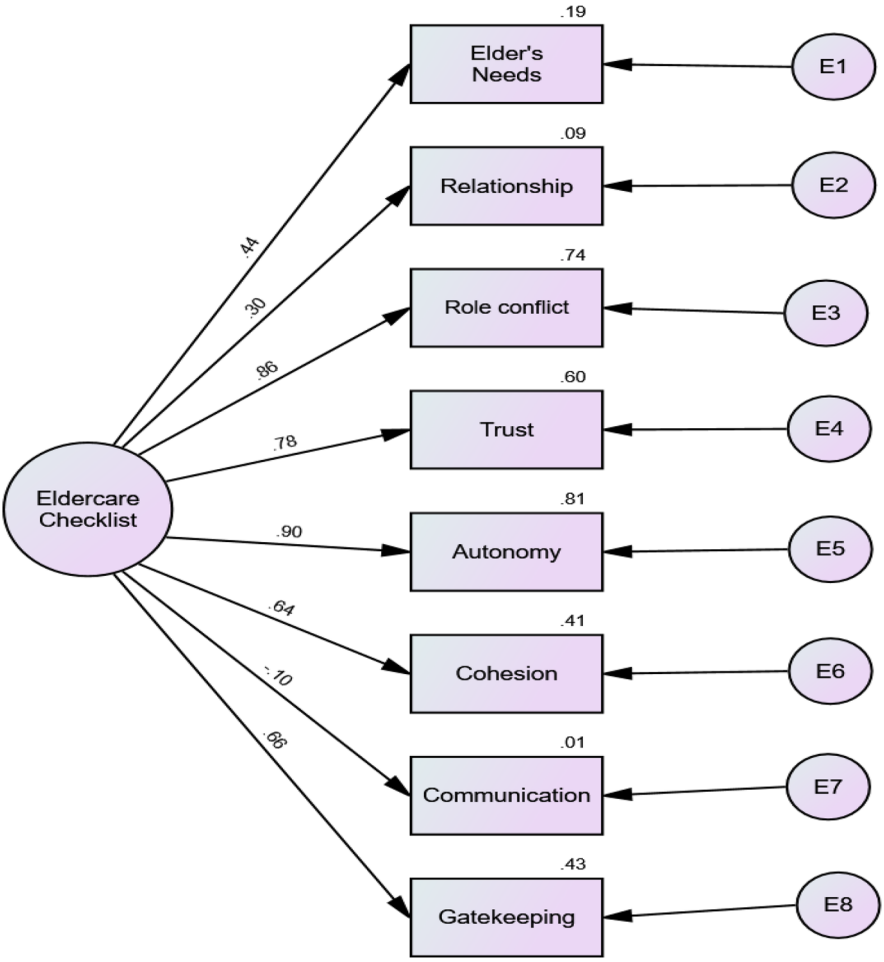

Fig. 2 ECC Measurement Model

(communication; relationship satisfaction) to rather poor (gatekeeping). Models fit indices, which are detailed in Table 3.

The variation on each of the subscales was significantly associated with the ECC as a whole ($P < 0.01$) except for communication ($p = 0.360$). The ECC explained between 9% of the variation (on relationship satisfaction) and 81% of the variation (on elder autonomy). Between 41% (family cohesion) and 81% (elder autonomy) of the variation on five subscales found to be strongly correlated with the ECC was significantly explained by the ECC, suggesting these subscales accounted for most of the ECC as a whole (see Table 4).

Qualitative Results

The respondents found the ECC to be "thoughtful and useful" and a "valuable tool in determining the needs and situation of the elder." One respondent indicated that the tool encouraged them to think deeply about many aspects of the family relationships and the older adult's needs that they could otherwise overlook. Likewise, others appreciated the ability to "systematically cover relevant areas to assess," and the tool provides an "easy-to-use checklist that encompasses many issues." A participant noted that the tool was "very useful… want to adopt it in consulting with clients and suggest family members use it to flush out different perspectives." While most appreciated the comprehensiveness of the tool, others would have appreciated a shorter version; "It is too long. The categories of the checklist are well-selected. A shorter version could be helpful for the eldercaring coordinator." Another noted, "This tool could guide an assessment interview, but may be too long to be effective as a 'tick and flick' for a client with diminished capacity."

Most participants believed the ECC would be helpful to use in the intake stage as a "good start for Intake and first two meetings." Others noted that the tool is a great baseline to assist the family in understanding where conflicts are" and that it is "helpful to outline the family situation and determine questions for further clarification." As one participant noted, "The tool seems very helpful in asking questions

Table 3 Model fit indices entire measurement model for ECC and for each of the factors

	Chi-Square	DF	P	RMR	GFI	CFI	NFI	RMSEA
Full model	72.70	20	< 0.01	1.92	0.85	0.84	0.80	0.16
Elder Needs	56.29	20	< 0.01	0.09	0.87	0.77	0.70	0.13
Relationship	2.18	2	0.33	0.03	0.98	0.99	0.96	0.03
Role Conflict	94.22	27	< 0.01	0.15	0.81	0.71	0.65	0.15
Trust	44.58	14	< 0.01	0.17	0.90	0.68	0.62	0.14
Autonomy	57.17	14	< 0.01	0.14	0.86	0.79	0.75	0.17
Cohesion	16.88	9	0.05	0.08	0.94	0.97	0.94	0.09
Communication	0.76	5	0.97	0.08	0.99	1.00	0.99	0.00
Gatekeeping	325.49	77	< 0.01	0.24	0.70	0.51	0.46	0.17

Table 4 The ECC 70 items loading on the 8 subscales

1. Elder's needs (9 items)			
Item	P	Standardized regression weights	Squared multiple correlations (proportion of variation predicted)
1. Elder has diminished cognitive capacity and requires assistance from others to make decisions.	<.01	.472	22.3%
2. Elder has mental health issue and requires support from others.	< .01	.518	26.8%
3. Elder has maladaptive coping strategies and requires assistance from others in coping.	< .01	.522	27.3%
4. Elder has a current substance misuse problem and requires the support of others to manage substance use.	.002	.438	19.2%
5. Elder requires supportive equipment for mobility.	< .01	.608	37.0%
6. Elder requires supportive services for daily tasks.	< .01	.639	40.8%
7. Elder depends on the caregiver(s) for instrumental care.	< .01	.596	35.6%
8. There are several family members involved in the care of the elder.	.024	.281	7.9%
9. Professional caregiver(s) are involved in providing care for the elder.	.001	.473	22.3%
2. Relationship satisfaction – 4 items			
Item	P	Standardized regression weights	Squared multiple correlations (proportion of variation predicted)
10. Primary caregiver feels supported by other family members.	< .01	.589	34.7%
11. Primary caregiver is appreciative of what other family members offer/do for elder.	< .01	.816	66.6%
12. The time the primary caregiver spends with the elder is supported by other family members.	< .01	.643	41.3%
13. Elder and primary caregiver spend time together outside of caregiving responsibilities.	.034	.250	6.2%

Table 4 (continued)

1. Elder's needs (9 items)			
3. Role conflict – 10 items			
	P	Standardized regression weights	Squared multiple correlations (proportion of variation predicted)
14. Primary caregiver feels stress due to competing roles.	< .01	.426	18.1%
15. Primary caregiver is satisfied with and/or willingly accepts the caregiving role.	.003	.418	17.5%
16. Primary caregiver spends the majority of time caring for the elder.	.004	.383	14.7%
17. Primary caregiver takes time for themselves.	.003	.398	15.8%
18. Primary caregiver blames the elder for interfering in other roles.	<.01	.524	27.5%
19.Primary caregiver burdened by financial expenditures/ obligations for elder.	.016	.301	9.0%
20. Primary caregiver is not supported by immediate family.	<.01	.498	24.8%
21. Family members vilify each other.	.002	.447	20.0%
22. Primary caregiver perceives jealousy or suspicion from, or feels the need to be defensive toward other family members.	<.01	.786	61.7%
23. Primary caregiver perceives other family member(s) disengaged from elder's needs/limitations.	<.01	.819	67%
4. Trust in decision making – 7 items			
	P	Standardized regression weights	Squared multiple correlations (proportion of variation predicted)
24. Elder and primary caregiver generally share major decisions.[R]	< .01	.580	33.6%
25. Family members do not trust primary caregiver's decision making about the elder.	.642	.051	.03%

Table 4 (continued)

1. Elder's needs (9 items)			
26. Elder reports distrust in the primary caregiver's decision making.	<.01	-.889	79.1%
27. Professionals involved with the family have different opinions about decision making.	.549	.065	.04%
28. Primary caregiver trusts the professionals involved to provide support and care to the elder.	.089	.189	3.6%
29. Elder feels decisions made by the primary caregiver do not accurately represent his/her wishes.	< .01	.889	40.3%
30. Family questions financial expenditures or expenses.	.961	.005	0%
5. Elder autonomy – 10 items			
	P	Standardized regression weights	Squared multiple correlations (proportion of variation predicted)
31. Primary caregiver criticizes the elder for not doing more independently.	< .01	.731	53.4%
32. Elder perceives demands made by the primary caregiver as excessive.	< .01	.502	25.2%
33. Elder perceives self as an imposition on the primary caregiver.	< .01	.573	32.8%
34. Primary caregiver perceives requests by elder as illegitimate demands.	<.01	.660	43.5%
35. Elder does not accept his/her dependency on the primary caregiver for supporting instrumental needs.	.047	.217	4.7%
36. Elder is satisfied with the professional supports.	< .01	.563	31.7%
37. Elder trusts the paraprofessionals involved to provide support and care for daily tasks.	< .01	.486	23.7%
38. Elder is satisfied with current living arrangements.	.953	.006	0%
39. Elder lacks private space.	<.01	.756	57.2%

Table 4 (continued)

1. Elder's needs (9 items)			
40. Elder's mental health interferes with relationships with family.	.043	.221	4.9%
6. Family cohesion – 11 items			
	P	Standardized regression weights	Squared multiple correlations (proportion of variation predicted)
41. Elder had a conflictual childhood experience with the primary caregiver.	< .01	.200	4.0%
42. There is a history of intimate partner violence within the family.	.051	.882	77.7%
43. Primary caregiver has previously harmed elder.	.051	.851	72.5%
44. There is a history of child maltreatment within the family (any family member toward any child).	.063	.519	26.9%
45.Elder has previously harmed family member.	.051	.872	76.0%
46. Elder and primary caregiver share similar opinions on social/political issues.	.057	.637	40.5%
47. The family sticks together to form a united front when talking with professionals.	.077	.391	15.3%
48. There are splits/alliances between family members.	.649	.049	.2%
49. Prior family conflicts resurface during arguments among family members.	.516	.071	.5%
50. Elder and the primary caregiver report feeling close to each other.	.134	.234	5.5%
51. There is a strong sense of importance of the family unit among family members.	.128	.243	5.9%
7. Communication – 5 items			
	P	Standardized regression weights	Squared multiple correlations (proportion of variation predicted)

Table 4 (continued)

1. Elder's needs (9 items)			
52. Family members are able to freely express their concerns, worries and fears respectfully to each other. [R]	<.01	.328	14.8%
53. Communication between family members is strained.	.004	.683	47.0%
54. Communications are blameful and attacking of each other.	.004	.801	64.0%
55. Family members avoid communicating with one another.	.006	.591	34.0%
56. Family members are unable to effectively communicate without the assistance of a third party.	.009	.490	24.7%
8. Gatekeeping – 14 items			
	P	Standardized regression weights	Squared multiple correlations (proportion of variation predicted)
57. Elder is isolated by family member(s) from his/her community.	<.01	.505	25.5%
58. Elder is involved in community activities.	.002	.375	14.0%
59. Elder has supportive community connections.	<.01	.417	17.4%
60. Primary caregiver facilitates the relationship between the elder and other family members.	.086	.190	3.6%
61. Primary caregiver restricts contact between the elder and other family members.	.002	.373	13.9%
62. Family member alienates elder's affection.	<.01	.563	31.7%
63. Family member withholds medical information from family member(s).	<.01	.767	58.8%
64. Family member withholds financial information from family member(s).	<.01	.775	60.0%
65. Primary caregiver provides periodic accounting of elder's income and expenditures to elder and/or elder's family.	<.01	.559	31.3%

Table 4 (continued)

1. Elder's needs (9 items)			
66. Family member using elder's financial assets for personal benefit without transparency.	<.01	.578	33.4%
67. Family member using elder's assets solely for elder's benefit with transparency but other family members are (still) not satisfied.	<.01	.425	18%
68. Family members are jealous of relationship between primary caregiver and elder.	<.01	.441	19.4%
69. Primary caregiver is compensated from elder's assets for providing the elder with care and/or for housing the elder.	<.01	.477	22.8%
70. Primary caregiver financially contributes to elder's household expenses while living in elder's home and providing care to elder.	<.01	.502	25.2%

that, if explored in intake and assessment, would better map the conflict in the scenario and better assess the older adult and the primary carer's perspectives." While perhaps useful as an intake tool, one participant cautioned that "this is not unlike the intake we do for all family conflicts. I think it could be a good guideline but need to be able to allow for individual situations."

The respondents also believed that the ECC appears useful for informing and guiding mediation and dispute resolution by providing the mediator/facilitator with a comprehensive view of the conflict and a "great conflict mapping tool for mediation, tool for assessing needs for support people or services." A participant noted, "Could help mediation by guiding conflicting parties to what is best for meeting needs of older adult." Another participant suggested that the tool's utility goes beyond mediation: "Anyone involved in case management, mediation, aged care service providers, health professionals…Anyone trying to make sense of the needs, interests, and rights of the older client themselves could use this tool as a basis for an interview with the client and their various family members and carers."

Possible barriers to using the ECC included first developing "trust before the elder or family will share info on some of these issues." Another potential barrier is the uniqueness of each case. "Literacy, education, understanding [are needed to answer the ECC]", and "cultural differences."

Discussion

This research intended to assess the reliability of the ECC in identifying factors leading to or exacerbating discord to help professionals reduce family conflict regarding the care and safety of an aging loved one. This is the first known tool to help eldercaring coordinators and other professionals differentiate levels and types of conflict in older families to help them target strategies and interventions to support the quality of life of the older adult. Based on the qualitative feedback from the participants, the ECC has the potential to help identify types of care being provided to the older adult (e.g., personal needs, activities, transportation) and by whom (e.g., family member, professional) and potentially how well (e.g., satisfaction of older adult or others). Attention to these details could help avoid duplication of services, conserving time and resources of the older adult and participants while providing more productive care for the older adult. With the development of a more efficient service delivery system for older adults, the older adult and family members may have the opportunity to reallocate financial and non-financial resources, reducing stressors as other options become viable.

The ECC, as a whole, showed excellent internal consistency. In addition, five subscales of the ECC were shown to identify those areas of concentration most worthy of targeted intervention: role conflict, trust, autonomy, family cohesion, and gatekeeping.

Elder autonomy was identified as central to the overall construct of eldercaring conflict. Keeping the older adult's voice at the center of the conversation, including their needs and preferences, is paramount to the role of the eldercaring coordinator. Being more aware of the perceived and actual autonomy of the older adult can help the eldercaring coordinator choose interventions that strengthen the older adult's

autonomy and support older adults' participation as fully as is safely possible in the decisions affecting them.

Gatekeeping was another area identified as a significant subscale. Gatekeeping originally referred to the access to information, time, and affection each parent had with their children. An "open" gate was facilitative of a parent's role, while a "closed" gate denied such access. Similar gatekeeping behaviors are relevant when assessing family members' encouragement of time with affection between and information-sharing about an older adult. Negative interactions and more restrictive sharing of information and resources often result in poor outcomes (Sapin et al., 2016). Even in highly cohesive family contexts, interference and control from family members is frequent and consequential (Widmer et al., 2018). The degree of gatekeeping is most often commensurate with the level of conflict and power struggles within the relationships between family members. Using the ECC could help eldercaring coordinators and other professionals explain to older adults and family members the particular gatekeeping behaviors that are interfering with their communication and decision-making, as well as the older adults' general quality of life.

Communication was not significantly correlated with the ECC scale as a whole or with any of the subscales, except for a significant albeit weak correlation with Relationship Satisfaction (0.283) and a weak negative correlation (-0.311) with the subscale of Trust. This may be because the general communication patterns of the older adult and family permeated through all of the more significant subscales.

It is important to emphasize that the ECC is not a replacement for comprehensive screening of abuse and violence mental health issues or capacity/disability of participants. More specific screenings are better used to address appropriateness or rule out cases for eldercaring coordination or other processes (e.g., MASIC, American Bar Association Elder Abuse and Neglect Screening Guidelines for Mediators), as well as to identify safety precautions and other strategies that would protect participants and increase their ability to participate most productively. The ECC is not a diagnostic tool but may point to the need for a more in-depth evaluation by a qualified professional before initiating services with a particular family or including a specific family member.

Implications for Practice

Interestingly, "Eldercaring Coordinator" was not a choice for the primary professional practice of those completing the survey. Qualifications for eldercaring coordinators, according to the Association for Conflict Resolution Guidelines for Eldercaring Coordination, are predicated on extensive training (including family mediation, elder mediation, and eldercaring coordination) of professionals "licensed or certified by a regulatory body of a jurisdiction, state or province, with at least a master's degree" and "extensive practical experience in a profession relating to high conflict within families." Since the field of eldercaring coordination as a practice area is new, with the first Training for Eldercaring Coordinators in 2015, current eldercaring coordinators are continuing in their primary profession, generally as mental

health providers/psychologists, attorneys, family and elder mediators, guardians, and parenting coordinators; all of which can also benefit with the use of the ECC.

Issues regarding an older adult are often convoluted by the family's fundamental dynamics (Lashewicz & Keating, 2009), including long-standing sibling relationships (Podgorski & King, 2009) and personal agendas. Numerous unsuccessful attempts to resolve past issues often reinforce polarization, resulting in greater resistance to addressing current issues more productively (Castronova, 2018). Family members in conflict vary in their ability to cope and adjust to difficult situations. Identifying the degree to role conflict, trust, elder autonomy, family cohesion, and gatekeeping play in the current discord among family members may be crucial in providing productive interventions to address disruptions in the care and decision-making of their aging loved one.

Furthermore, courts and professionals can embrace various processes designed to empower people to manage their situations and explore possibilities for resolution. Self-determination is a keystone in mediation and is one of the central justifications for diverging from the traditional process offered by courts (Boyarin, 2012). Yet there is still a risk of using the mediation process to coerce another person into an agreement, using leverage from differential power, or when one or more participants cannot meaningfully participate due to cognitive decline, substance abuse, mental illness, etc. (Crampton, 2013). Understanding the environment of the dispute through the ECC allows the court and professionals to consider differentiated case management that considers the unique needs of each specific family. Through the use of the ECC, they can better identify intervention(s) most likely to address the type of conflict and capacity levels of family members, promoting their participation in decision-making, including the older adult to the extent possible, in a non-coercive environment, thus providing a long-term sustainable resolution.

Limitations

It is important to note the following limitations of this study. While the professionals completing the survey approached the scenario similarly, there is no way to know if they would continue to assess other cases similarly or what aspects of a case would produce differences in their perceptions. Eventually, when eldercaring coordinators are more experienced, it will be interesting to see if they, as a group, also approach their cases similarly to those in other professions. Also, the length of the survey was an impediment expressed by some of the professionals. As a screening tool, it may be more advantageous to have a shorter version or a version specifically reconstructed for judges, magistrates, and court staff to indicate the degree of conflict and refer the family to the most appropriate process (e.g., mediation or eldercaring coordination).

Another important limitation is that the survey, on its own, did not allow for differentiation depending on cultural and other diversity differences in families. This would include the potential incongruities when older generations have migrated from their original residential location, be it from state to state, province to province, or country to country, where long-standing beliefs, attitudes, and caregiving

behaviors are in opposition or contradiction to the location to which they have immigrated. Similar complications can occur when new family members' (e.g., spouses, stepchildren) expectations and behaviors interfere with caregiving or exacerbate conflict between family members. There may also be complications when the primary decision-maker or caregiver lives far from the older adult and provides oversight. Others having more frequent or even daily responsibilities may be resistant or resentful of decision-making, made even more impersonal when imparted by telephone, email or text, especially without previous discussion or input.

Finally, while a primary intention is for the professional to use the ECC to identify a typology of conflict with the ability to choose targeted interventions better, the tool does not include a list of strategies or interventions that might be most useful depending on the survey outcome.

Future Research

The ECC is the first study of its kind to ascertain the use of an assessment tool to help professionals identify the typology of conflict in older families. The ECC was based on the ecological transactional model; further study may be needed to validate the use of that model for this purpose and to determine if another model might be as or more useful. Future research can illuminate which and how specific professional fields working with elders and older families in conflict in addition to eldercaring coordinators (e.g., mental health providers/psychologists, attorneys, family and elder mediators, guardians, and parenting coordinators, among others) would most benefit from use of the tool. Additionally, exploration could verify if the self-administration of the tool by the elder and each family member can be a useful approach to augment those surveys completed by the practitioners. It may also validate the benefits for health insurance companies (providers of Medicare/Medicaid) to use the survey and medical practitioners since family conflict is a stressor that adds to health concerns.

Developing a shorter and more focused screening to help the court and intake professionals with better referrals for families in high conflict is also prudent. This is especially important given the results that showed that some subscales (i.e., Trust in Decision Making) had questionable levels of internal consistency, and the loadings show weaknesses in some of the items. Continued study is also needed to identify ways the subscales can be used independently or in smaller groupings or how the current survey can be shortened and still provide significant outcomes. Therefore, further testing of the tool will include the removal of certain subscales and/or items to create a shorter version of the tool. This will also address the qualitative comments from the participants that the tool itself needs to be shorter to complete.

It would also be helpful to explore possible interventions and strategies for professionals to use that target specific subscales and behaviors based on the survey outcomes. In this way the ECC can most effectively be applied to benefit older adults and their unique families. A study of using the ECC as both a pre-and post-test could determine if the targeted intervention benefitted the older adult and family.

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Data Availability The data that support the findings of this study are available from the corresponding author, MS, upon reasonable request.

Declarations

Conflict of Interests All authors declare no conflict of interest.

Informed Consent None.

Ethical Treatment of Experimental Subjects (Animals and Humans) No experimental treatment was conducted on either human or animal subjects in this study.

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Linda Fieldstone, M.Ed. is a distinguished figure in family law. As Co-Chair of the ACR/FLAFCC Elder Justice Initiative and past President of AFCC, she played a pivotal role in developing parenting coordination. Fieldstone's 26-year tenure as Supervisor of Family Court Services in Miami-Dade County reflects her expertise in handling high-conflict families. She is involved in international training and research and

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Sue Bronson M.S. a mediator and psychotherapist since 1983, brings compassion to conflict resolution. Serving as Past Chair of ACR's Family and Elder Sections, she actively promotes quality mediation services. Bronson's gentle guidance aids clients in making informed decisions, resolving conflicts with dignity, and moving forward positively. She contributes to mediator professionalism as the lead author of the Self-Assessment Tool for Mediators. Engaging in training, reflection, and consultation, Bronson remains a steadfast advocate for excellence in mediation, enhancing individuals' lives through effective conflict resolution in her private practice in Milwaukee, WI.

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