

# Palliative Medicine Grand Round

## Manipulative client, manipulative interactions

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### Case history

Ms A, a 74-year-old lady, suffered non-small cell lung cancer with brain secondaries. On examination, Ms A was unconscious but arousable. Neurological examination revealed bilateral sixth cranial nerve palsy and absence of the gag reflex. Ms A's husband died 20 years ago. She had a son who lived in Australia, and a daughter, Ms B, who was a clinical psychologist. Ms A had assigned her son as proxy to make decisions regarding her medical care, witnessed by a solicitor.

The staff considered Ms B's manner rude, and her demands often 'unreasonable'. These included frequent telephone calls to the ward or the doctors to ask for details about the patient's condition, and insisting on immediate action for non-urgent matters. She also demanded oral feeding of her mother despite absence of the gag reflex. She made frequent complaints about the ward staff.

The team decided that the goals of management were to negotiate a mutually agreed care plan and provide quality care to the patient, and if possible, to the family members as well. Another goal was to minimize the negative staff emotions in looking after this patient. The strategies used to achieve these goals included *enhanced staff support and teamwork*. Staff members were encouraged to ventilate their emotions with colleagues. The senior staff had to take up responsibility and whenever the staff had problem with Ms B, they could direct her to the senior staff. The second strategy used was *asserting, obtaining verbal agreement concerning the care process, and consistency in care*. The team decided, and asserted to Ms B, that to protect confidentiality, patients' data should not be disclosed over the telephone, and that for Ms A, nasogastric tube feeding was indicated. The team obtained verbal agreement on this from Ms B. An on-call doctor subsequently agreed to disclose the patient's data to Ms B over the telephone. Ms B was then told that the team did not agree with the decision of that on-call doctor. The third strategy used was *nurturance and challenge*. We reassured Ms B that we respected her as the patient's daughter, and that she had the right to be informed of her mother's condition. We reassured her that it was the hospital's policy not to disclose patients' data over the telephone to ensure confidentiality and was nothing personal to her. We empathized with her feeling upset if she was not involved in the decision-making process. However, when she made unreasonable comments and complaints, we requested her to clarify the issues, and sometimes asserted strongly our professional opinion.

Ms A never recovered from the pneumonia and died with Ms B by bedside. While Ms A was gasping, Ms B went out to buy some egg tarts to thank the staff.

## Discussion

Manipulation is a maladaptive coping strategy that a person employs to get his/her needs met without regard for others. It triggers angry responses from others, aggravating the person's anxiety, loneliness and insecurity. In the healthcare setting, manipulative behaviours include instant intimacy, team splitting, threats, frequent and excessive demands, and constant complaining and dissatisfaction with the care provided. Approaches to a manipulative patient include improving the staff's own self-awareness, verbal contract with the client, consistency in care, and enhanced communication among the staff such as team conference<sup>1</sup>

In an interaction, each other's behaviour is mutually constructed and regulated. We should take responsibility for constructing the pattern of interaction. Therefore, if the client continues to manipulate us, we are partly responsible for that. Instead of blaming a manipulative client, systems thinking focuses on the manipulative interaction produced by the professionals and the client together. Although the context is different, the principle and technique of nurturance and challenge used by Minuchin in family therapy<sup>2</sup> can be used to change the pattern of interaction between a client and the carer. By challenging the client, tension is created, and out of discomfort, both parties will access their strength and create change in the pattern of interaction. However, the carer had to stay within the client's acceptable range when challenging, and challenge should be balanced with nurture.

In the management of our client, the team was pleased that the client expressed her appreciation of our care, and was also pleased with the teamwork. A manipulative client could be an opportunity to increase cohesiveness of the team.

## References

1. Nield-Anderson L, et al. Responding to 'difficult' patients. *Am J Nurs* 1999; 99: 26-34.
2. Lee WY. The shit-painter. In: Minuchin S, Lee WY, Simon GM (eds). *Mastering Family Therapy*. New York, John Wiley & Sons, 1996: 199.