MANAGEMENT OF THE ANGRY PARENTS OF SEVERELY ILL CHILDREN

Ujwal Sardesai
Sudhir Mishra

Anger is most distressing response of parents and hospital staff to sickness of child. Since the course and outcome of illness is variable and often unpredictable, the response of individual to it is likely to be variable. Nevertheless, long term studies on reaction patterns of patients with severe illness(l), dying patients(2), relatives of such patients(3), following birth of malformed(4) or stillborn infants(5) and even grief reaction of the child to parental loss(6) show predictable patterns with anger being part and parcel of it *(Table I*). However, there is scant literature available regarding reaction of parents to an acute illness of the child. Our experience suggests that the pattern is similar with phases in rapid succession overlapping each other.

One of these reactions, anger, being an irrational emotion, is always counterproductive, even hinders in adequate management of patients. It interferes with proper communications, thus inadequate or false history, wastes time and effort, decreases compliance, delays treatment, leads to doctor shopping and increases expenses. Recognizing parental anger decreases professional exhaustion, leads to increased satisfaction and avoids tense situations because of intellectual, emotional, physical and even legal disputes. Experience shows that "angry parents do not pay" (fees/expenses)(7). At the same time anger in parents leads to inadequate care which in turn escalates anger and creates a vicious cycle. Thus, in pediatric practice, importance of managing angry parents is self evident.

How to Recognize Anger?

Anger manifests itself in two ways, overt or covert. It is easier to recognize overt anger which manifests itself in the form of frowning, facial expressions such as bared teeth, furrowed brows, pouting, raised and pressured voice, verbal accusation, menacing body postures, intimidating language and physical violence(8). Covert anger is more difficult to recognize but is equally exhausting and distressing to professionals. It arises from a passive aggressive trait and manifests by procastination, *e.g.,* not giving adequate' history, being sulky, or impassive, deliberately slowing management by delayed and terse

From the Departments of Psychiatry and Pediatrics, Mahatma Gandhi Institute of Medical Sciences, Sevagram, Wardha.

Reprint requests: Dr. Sudhir Mishra, Reader, Department of Pediatrics, MGIMS, Sevagram, Wardha 442 102, (M.S.).

TABLE I-*Reaction Patterns in Different Situations*

Patients with severe illness	Dying patients	Relatives of dying patients	Parental reaction to birth of malformed baby	Grief reactions of child to parental loss
Immediate coping Outcry Denial	Shock & Denial	* Preoccupation * Sense of abondonment (guilt & irritability}	Shock Denial	Immediate reaction (from indifference to devastation)
	Anger	* Anger * Loss of habitual pattern of conduct	Sadness & Anger	
Intrusion experiences	Bargaining Deperession	Protest reaction		Intermediate reaction (alternating playfulness with grief)
Working through		Resolution	Equilibrium	Long term effects *Predisposition to mental illness especially depression, poor school performance, delinquincy
Completion	Acceptance	Detachment	Reorganization	

responses, *e.g.,* not giving consent for procedures or unwarranted protects. Parents with covert anger may resort to unreasonable criticisms, scorns or may obstruct by failing to do their share in management of the child by giving petty reasons, *e.g.,* forgetfulness.

Sources of Parental Anger

In clinical setting parental anger arises from multiple sources. For the purpose of understanding, these can be divided into situational, psychosocial and emotional. Each of them can be related to health facility, illness of the child, parents themselves or staff caring for the child *(Table II).* The situational problems arising from the health facility itself, *e.g.,* long hours of waiting or seeing another patient first because of his disease condition, may give rise to anger in a parent who is already irate because of the overcrowding and clerical necessities which are essential for hospital administration but seem unwarranted to the parent of a sick child. Understaffing may further contribute to this situation.

Repeated evaluation because of the nature of illness or by medical students may

TABLE II-*Sources of Anger*

	Situational	Psychosocial	Emotional
(a)	Ignorance	Economic	Overprotective parent
	p Exhaustion	Intrafamilial	Anxious pent
	A	conflicts	
	R Sleep	Guilt	Emotional disorder in
	E deprivation		parents
	N Hunger thirst	Helplessness	
	T Medical illness		Personality disorder
	S in parents		Hidden anger
	Substance abuse		
(b)			
	F Waiting	Nonavailability of	Prejudice against the
	A Overcrowding	services	system
	C Clerical		
	I neccessities		
	L Repeated		
	I evaluation		
	T Understaffing		
	y		
(c)	Repeated	Social stigma	Prejudice about the
	I evaluation		nature of illness
	L Nature of illness		
	L Severity		
	N Chronicity		
	E incurability		
	S inmicability		
	S Effects of medication		
(d)			
	S Exhaustion	Intrafamilial-	Intrastaff conflicts
	T Sleep deprivation	conflicts	Personality variables
	A Hunger/thirst	Helplessness	
	F Medical illness		
	F Substance abuse		

also give rise to anger. Incurable. chronic. severe and debilitating diseases invariably lead to frustration and evoke anger in some parents. Similarly an apparent deterioration

in child's condition due to side effect(s) of the drug(s) administered may lead a parent to consider it an error of judgement or negligence and provoke a parent(9). False perception about the severity of illness and consequent high expectation arising out of ignorance are often contributory. A parent with hysterical personality or hyperthyroidism is certainly more irritable and predisposed to anger as is an intoxicated person. Diseases with social stigma generate feeling of guilt and helplessness and make a parent irritable and angry. Similarly, prejudices against the system, especially Government hospitals in India, predispose to anger. Occasionaly a parent may stage a pseudoangry drama(10) to manipulate the system for gains, *e.g.,* seeking attention or getting fees waived or free drugs. Personality variables in staff lead to variable reactions to same situation which may baffle parents and make them angry. It is documented that psychiatry residents with higher irritability scores call for more physical attacks(11).

Professional Response to Parental Anger

Just as parents are under stress, so are professionals, specially in an emergency setting(12,13). When stress reaches a threshold, it creates frustration and in turn anger. Professionals who often face these situation build up psychological defenses to avoid anger in themselves. Nevertheless, these defensive manouveres may be counterproductive in the sense that they deal with the professional's reaction only and not necessarily with parental anger. In fact such manouverses, *e.g.,* turfing, walking out of the situation, overt confrontation, *etc.* escalate parental anger.

How to Deal with Parental Anger?

Various factors leading **to** anger have already been described. The situations leading to them are almost invariably multifactorial and their assessment requires ongoing vigilance by professionals. The essential requirement is empathy—best described as emotional understanding of the problems, achieved by paying attention to family as a unit and hence the importance of often neglected social and family history. Another important aspect is the knowledge of symptomatology of covert anger which usually precedes overt anger. The severity of anger lies in a continuum from covert to overt starting from irritability, undue interference to frank hostility(14).

The above assessment would lead to identification of the problem areas and help in formulation of strategies to deal with them *(Table HI).* It is also essential to identify the area of mutual agreement between the parents and professional. Spelling out priorities starting from such an area helps in pacifying majority of parents. In our experience, attention to the sick child is usually the common area of agreement, which is not difficult to achieve. This should be followed by sharing information about the nature and severity of child's illness and the possible remedial measures being taken with the

TABLE III-*Dealing with Parental Anger*

*	Recognition of source
*	Empathy
*	Reassurance and counselling
*	Setting limits
*	Time out
*	Refusal to treat
*	Tolerate
*	Prevention of anger in parent
	—Recognize your own reaction
	—Avoid acting out
	—Removal of known source(s) of anger

angry parents. To a parent who is angry because of facility and/or staff related factors, which is common in Indian rural setting, a calm explanation and a gentle apology (even if the problem may not be of the professionals own creation) is most helpful. Providing apt and timely reassurance and prognosis often prevents, diffuses and terminates the progression of parental anger. Despite the best efforts, a professional may not succeed everytime. An angry parent may be requested to stay in waiting area and cool down before treatment can be started. However, in life threatening illness, preliminary treatment has to be started during this time. Many parents can be pacified in this manner. If even after all efforts, parent(s) are hostile, violent or intoxicated, protection of staff becomes mandatory. Presence of a security personnel instills a sense of order and control over the situation and ensures timely intervention, whenever required. It may be necessary to force the angry parents away from the child into waiting hall to ensure speedy management of the sick child. Nevertheless, sometimes this "time out technique" is not successful and the violence can only be prevented by refusing to treat the child as parents are noncompliant. They should be asked to return, when co-operative. In a tricky situation, where the child is likely tp die without or with treatment, it is for the sake of the child that otherwise unacceptable parental behavior may have to be tolerated(9).

Although, having an encounter with an angry parent is draining, frustrating and even depressing, the staff must guard against over-reacting to parental anger, displacing anger on to the patient and tendency to abandon the patient. Last but not the least, care should be taken by administrative authorities to minimize staff and facility crunches.

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