The Conflicted Surrogate Syndrome: Implications for Nursing Facility Work Force Stress, Safety, and Turnover

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When a loved one is admitted to a nursing facility, family members usually experience a variety of emotions. Feelings of guilt, fear, and distrust are common. The facility staff must make every effort to engage the family and establish trust to forge a constructive collaboration in the care of the nursing facility resident. Even with conscientious and compassionate staff efforts to establish an alliance with family members, however, maladaptive family responses can occur. Kidder and Smith have analyzed maladaptive family responses characterized by excessive complaint behaviors and have proposed that this constitutes a recognizable syndrome they named “The Conflicted Surrogate Syndrome.” This article proposes diagnostic criteria for the syndrome, presents 3 cases meeting the criteria, and offers suggestions for early recognition and intervention. The potential for violence against nursing facility staff by the conflicted surrogate and the impact of the syndrome on work force stress, safety, and turnover are discussed. Licensing and certification agencies, ombudsman programs, and advocacy groups, as well as nursing facility clinicians, staff, and leadership must acknowledge the potential threat this syndrome contains for nursing facility staff. Although the modern focus is on resident rights, the nursing facility is a community in which all members, including the staff, must be afforded an environment that is free from verbal abuse, intimidation, and threat of physical violence.

In 2006, Kidder and Smith1 reported 4 cases of families whose complaints about nursing facility care were deemed unwarranted or excessive, and at times, irrational. The cases were analyzed in psychoanalytic terms and hypotheses were generated about various psychopathologies within the family members or family systems, leading to the abnormal complaint behaviors. They proposed that the cases might represent a recognizable syndrome they labeled “The Conflicted Surrogate Syndrome.” Kidder and Smith1 hypothesized that the excessive complaint behaviors might have a negative impact on care of the nursing facility resident, because of staff withdrawal from care and hesitancy to deal with the unpleasant interactions with the conflicted surrogate. The authors also stated that the focus on complaints by the regulatory agencies could be validating to the pathological complainer. Moreover, regulatory responses to each and every complaint may actually become countertherapeutic, reinforcing and promoting the pathological behaviors. They encouraged state survey agencies to make efforts to understand the concept of the conflicted surrogate syndrome and to consider the full context of repeated unsubstantiated complaints, rather than simply evaluate each complaint individually.

In 2007, Bright-Long and Kidder2 presented a session at the annual meeting of the American Medical Directors Association (AMDA) on “The Conflicted Surrogate Syndrome.” In 2012, Finely et al.3 presented a session at the annual AMDA meeting entitled, “A cross cultural ethics approach to the conflicted surrogate syndrome.” The components that emerged from these symposia and the article for recognizing and diagnosing the conflicted surrogate syndrome include the following:

1. Repeated complaints about nursing facility care that are unsubstantiated; or
2. A volume of complaints that is a statistical variant and outlier from the average volume of complaints from other family members of residents residing at the facility; or
3. Repeated complaints concerning issues that seem relatively minor to the staff in which the emotional reaction from the family member is significantly disproportionate to the magnitude of the alleged transgression; or
4. A “complaint portfolio” from a family member, including repeated complaints reported to licensing and certification agencies, requiring an inordinate amount of staff attention to manage the complaints and the complainer, such that it interferes with staff performance of their normal duties to other residents and families; or
5. Any complaint that includes verbal abuse, intimidation, or physical aggression toward staff members; and
6. Evidence of maladaptive behaviors or a psychiatric illness in the family member and/or family system.1–3

Kidder and Smith1 have pointed out that conflicted surrogates are often in denial about the family member’s true condition and
prognosis, and therefore blame the nursing facility staff for any evidence of decline. This denial may be a risk factor for developing the syndrome. The conflicted surrogate’s denial may simply reflect our broader cultural denial of aging, frailty, and terminal decline. Dr. Kate Scannell eloquently described this form of cultural denial in her essay, “An aging un-American,” stating that such denial can cause psycho-spiritual harm to older adults.\textsuperscript{4} The conflicted surrogate syndrome may represent how such denial can cause psycho-spiritual harm to the families of aging persons and also to the staff who care for frail elders experiencing terminal decline.

Kidder and Smith\textsuperscript{1} also found that conflicted surrogates often have a stereotypical negative attitude about nursing facilities. They may focus on every detail of care that is not perfect and fail to acknowledge any good care, or even extraordinary care, that is given. This prejudicial attitude may be a risk factor for developing the syndrome.

Conflicted surrogates may encourage complaints from other families. They may view themselves as advocates for “nursing home reform,” even though their dysfunctional behaviors may endanger residents by diverting significant staff time to managing the complaints and the complainer, and away from their regular duties of resident care. A self-concept as a reformer or crusader may be a risk factor for developing the syndrome. At times the actions of the conflicted surrogate may take the form of a battle against a particular facility or its leadership, such that the conflict becomes a crusade that takes on a life of its own and no longer is related directly to the care of the family member.

When abnormal complaint behaviors are accompanied by excessive documentation of every aspect of care and every alleged transgression, the motivation may be to “set the facility up for a future lawsuit” in the current litigation environment.\textsuperscript{2} A desire to punish the facility or to gain financial remuneration may be a contributing factor to the development of the conflicted surrogate syndrome.

Kidder and Smith\textsuperscript{1} note that even family members who do not abnormally complain are likely to experience a variety of emotions when a loved one is admitted to the nursing facility. Feelings of guilt, fear, and distrust are common. The facility staff must make every effort to engage the family and establish trust so as to forge a constructive collaboration in the care of the nursing facility resident. In a study of interactions between nursing facility staff and families, Utley-Smith et al.,\textsuperscript{5} described communication strategies that influenced staff-family interactions positively (Table 1). Maladaptive behaviors can and do occur, however, through family enmeshment, disengagement, or triangulation between the staff, the resident, and the family. Attempts at splitting the treatment team can be part of the triangulation behavior. Psychiatric diagnoses in the conflicted surrogate may include adjustment reaction, personality disorder, depression, bipolar disorder, and others.\textsuperscript{3} Preexisting psychiatric illness is a risk factor for developing conflicted surrogate syndrome, with the stress of nursing home admission tipping the balance into decompensation.

Grabowski and Mitchell\textsuperscript{6} studied the impact on family oversight of care in nursing facility residents with advanced dementia. They found a nonlinear relationship between family visit time and outcomes of care. Residents with very high levels of visiting experienced worse outcomes (less pain, fewer pressure ulcers, less dyspnea, fewer hospitalizations).\textsuperscript{6} Family members who visited for more than 7 hours per week had lower satisfaction with care compared with those visiting 1 to 7 hours per week.\textsuperscript{6} High number of hours of visitation each day or week may reflect a level of distrust of the facility, social isolation of the family member with lack of outside activities, or may be a manifestation of enmeshment psychology. The study did not distinguish cases in which a high number of visitation hours could reflect families conducting a “death vigil” with patients approaching an expected death. Excessive number of hours a day spent with the nursing home resident may be a risk factor for the conflicted surrogate syndrome.

In the March 2012 AMDA symposia, during the discussion of ethical dimensions of the conflicted surrogate syndrome, mention was made that “staff members have rights too.” “Verbal abuse of staff should not be tolerated. When slurs or threats occur, the facility is within its right to bar routine visiting or to take other necessary acts, including arrest, to protect its staff.”\textsuperscript{2} One reason to identify the conflicted surrogate syndrome early in its course would be to apply therapeutic interventions, so as to mitigate its potential for suffering and damage before the creation of crisis conditions. The family member manifesting the syndrome, the resident, and the staff may all suffer when the syndrome is not recognized as such.

### Case Reports

The following case reports and comments explore the conflicted surrogate syndrome from the perspective of nursing facility workforce stress, safety, and turnover. Possible mechanisms and interventions to manage conflicted surrogates before their behaviors escalate are proposed.

#### Case 1

In 2005, Elton\textsuperscript{7} published a case report of a nursing facility resident’s son whose interaction with the facility staff appears in retrospect to meet the definition of the conflicted surrogate syndrome. The son had cared for his 90+-year-old mother for many years before her nursing home admission. The patient had advanced stage dementia. The son was socially isolated and spent many hours with his mother daily. He made multiple calls to the corporate hot line, the ombudsman program, the licensing agency, and elected officials at all levels on a regular basis to complain about his mother’s care at the facility. He pounded his fists on the nursing station and yelled at the staff. The staff of the facility were so frightened by the son that one of them questioned whether he might return to the facility and open gunfire on the staff if his mother were to die there. Initially the facility’s administration encouraged the staff to try to meet the son’s demands and accommodate him. But this was impossible, because his complaints were excessive, often unwarranted, and at times, irrational. His pathology was reinforced by the recognition and validation he received from the survey agencies and nursing home advocacy groups, including an opportunity to testify at a federal congressional hearing on nursing home reform. Consultants were hired to try to provide the facility with the skills to handle the situation.
help the staff deal with the son, but despite their input, his behaviors escalated. One day he struck a facility staff member. The police were called, and assault charges were filed. The court found him guilty. His mother remained at the facility, but the son’s visiting privileges were curtailed. The mother lived to be more than 100 years old. After her death, the son continued to file complaints against the facility. He did not stop doing so until 2 years after the mother’s death, when the survey agency agreed to issue a deficiency citation against the facility based on the son’s numerous allegations. The citation was recorded as “past noncompliance.” Had this situation been recognized as a conflicted surrogate syndrome earlier and addressed accordingly, the situation might not have escalated to the point of a physical assault on the staff member.

Case 2

The daughter of a 90+-year-old woman with advanced stage dementia made numerous complaints and false accusations against the nursing facility staff where her mother resided. Her emotional reactions were disproportionate to the alleged transgressions. For example, the staff had the mother on a routine toileting schedule and she was dry most of the time, but did have episodic urinary incontinence. One day after lunch, the daughter visited and found the mother had a wet diaper, despite having been toileted before lunch. In response to finding her mother wet, the daughter began yelling at the staff and demanded that the administrator and director of nursing immediately be summoned to the unit. When they arrived, the daughter verbally berated them in front of their staff and residents. Her angry outburst frightened everyone who witnessed it. When staff tried to direct the daughter into a private area and calm her down, the daughter threw the wet diaper at a staff member, barely missing her. The police were called. Thereafter, the daughter’s visitation privileges were curtailed. She was required to have a security guard escort her to and from her mother’s room.

The daughter subsequently berated a facility staff member in a loud and very public way when they accidentally met while doing their shopping in a local grocery store. The daughter posted libelous accusations about the facility and its leadership on the Internet. A staff member at the facility stated a fear that this daughter might cause her bodily harm if they were to meet outside of the facility.

Several other staff members and residents experienced fear when dealing with the conflicted surrogate. The receptionist became tongue-tied and would visibly shake when confronted by this person. A floor technician feared being in the vicinity of the conflicted surrogate because of being badgered repeatedly for information about other residents, despite stating he could not discuss other residents with her. A resident sitting in the lobby diverted her eyes when approached by the conflicted surrogate, after witnessing her verbal abuse to staff in public areas. The presence of a security guard gave comfort and solace to some residents; however, it was discooncerting for some family members. “What’s wrong? Is my Mom safe here?” some family members asked. “Why don’t you just discharge the mother and get that daughter out of here?” they asked.

Case 3

A young man had a stroke followed by respiratory arrest with anoxic brain damage. His brain injuries left him functionally quadriplegic and nonverbal. He could smile and grimace, track with his eyes, and move his head. He had a permanent tracheostomy and feeding gastrostomy tube. His mother was retired, widowed, and socially isolated. She lived far away from the nursing facility, but refused to have the son moved to a facility closer to her home, stating they were all horrible places. She spent many hours each day in her son’s room. She initially tried to spend the nights in various parts of the nursing facility, but was prohibited from doing so. She often slept at night in her van parked in the facility lot.

Her anxiety escalated when her son was scheduled for major surgery. She called the facility every hour through the night before the procedure. The morning of the procedure she tried to cancel the operation, accusing the attending physician of not having performed an accurate preoperative assessment and accusing the surgeon of wanting to use her son as a “guinea pig to train the surgical house staff at the university.” Other times she demanded that her son be sent to the hospital, even when he was not acutely ill. The hospital staff accused the mother of pulling out the patient’s tracheostomy tube to create false emergencies. The mother made false accusations against several of the nursing facility staff caring for her son. At every nursing facility care plan meeting, she threatened to bring a lawsuit against the facility.

One day she struck a staff member. The police were called. The facility obtained a restraining order prohibiting her from entering the building. Over time, she was allowed to visit her son once a week, with a security escort. Court-appointed guardianship proceedings were initiated.

Discussion

In 2009, Leister explored workplace stress and intent to leave the profession for licensed nursing home administrators (NHAs) in Maryland. This quantitative study sought to determine the factors, stress, in particular, that could influence the NHA’s intent to engage in preparatory and/or active job search behaviors. Workplace stress predicted both preparatory and active intent to leave the profession ($p < .001$).

The survey asked NHAs to quantify the intensity of 35 workplace stressors listed in the Occupational Stress Questionnaire. Maryland administrators identified “unrealistic expectations of family members” among their top 5 stressors. “Unrealistic expectations of family members” is also found in the top 5 stressors identified by Virginia nursing home administrators. The conflicted surrogate syndrome represents “unrealistic expectations” taken to an extreme level. Although “unrealistic expectations” is not a defining feature of the conflicted surrogate syndrome, it may be the mind-set that is a risk factor or necessary condition for the development of the condition. The authors estimate, based on their more than 100 years of cumulative experience in the field, that approximately 1% of families of nursing facility residents meet the definition of conflicted surrogate syndrome with an estimated 25% to 50% of families having unrealistic expectations. But one conflicted surrogate in a facility, in addition to many families with unrealistic expectations, may create an intolerable level of stress for some staff.

In addition, “hours worked per week” was the only variable significantly related to active intent to leave the profession ($p < .05$). This finding could signify the tipping point in making the decision to leave. Conflicted surrogates consume an inordinate amount of the front-line staff and facility leadership’s time and energy. In a study of persistent discord between families and staff in nursing facilities, Marziali et al noted the excessive time demands involved in trying to cope with families who are in constant battle with the facility and the extreme stress levels these interactions can cause. When conflicted surrogates are active in a facility, time tends to be measured from one complaint or outburst to the next. It is hypothesized that the inability to effectively manage the conflicted surrogate syndrome is a significant contributing factor to staff turnover and decisions to leave the field entirely.

Interactions with the conflicted surrogate require facility leadership to call on their arsenal of coping skills in the search for a resolution to the complaint behaviors. Over time, the arsenal of coping
skills can become depleted. A response to a stressor and perceived threat may initially be constructive and positive, but over time may turn into anxiety, depression, or hopelessness if the situation is viewed as unsolvable. There may be a sentinel event that moves the situation into anxiety, depression, or hopelessness if the situation is threatened. A response to a stressor and perceived threat may initially be constructive and positive, but over time may become depleted. A response to a stressor and perceived threat may initially be constructive and positive, but over time may be depleted.

1. Are the proposed definition criteria for the conflicted surrogate syndrome adequately sensitive and specific to allow an accurate case definition? How can it be clearly distinguished from positive complaint behaviors that may promote quality care?

2. What is the prevalence of conflicted surrogate syndrome in American nursing facilities?

3. Can specific interventions be defined that are successful in relieving the suffering of the family member, resident, and staff members confronted with this syndrome?

4. Can the impact of the conflicted surrogate syndrome on the mental health and well-being of nursing facility staff be quantified?

5. Do residents whose family members are suffering from the conflicted surrogate syndrome have worse measurable outcomes when compared with a matched cohort of residents whose family members have a healthy adaptation to nursing facility life?

6. Can the impact of conflicted surrogate syndrome on nursing facility work productivity be measured, including the cost of staff response to a conflicted surrogate?

7. What other measurable impact does the conflicted surrogate syndrome have on nursing facilities? How much damage can the conflicted surrogate do to the reputation of quality organizations and honorable professionals working in the facility?

8. How can the advocacy and regulatory systems acknowledge the conflicted surrogate syndrome and work toward a therapeutic systems intervention, when appropriate?

As illustrated by these case reports, failure of early recognition and successful intervention with the conflicted surrogate has the potential for negative outcomes for the family member, as well as for the nursing facility residents, staff, and leadership. Licensing and certification survey agencies, ombudsman programs, and advocacy groups, as well as nursing facility clinicians, staff, and leadership must all recognize the conflicted surrogate syndrome. The syndrome must be acknowledged as a potential threat to workplace safety, and as a contributing factor to staff stress, burn out, and turnover. Although the modern focus is on resident rights, the nursing facility is a community in which all members, including the staff, must be afforded an environment that is free from verbal abuse, intimidation, and threat of physical violence.

### References


5. Utley-Smith Q, Colon-Emeric CS, Lekan-Rutledge D, et al. The nature of staff behaviors toward the staff, residents, or other families. Behaviors toward the staff, residents, or other families.


