

# Problem Patients in a Psychiatric Inpatient Setting

## An Explorative Study

Jiří Modestín, Erika Greub, and Hans D. Brenner

Psychiatrische Universitätsklinik (Direktor: Professor Dr. W. Böker), Bolligenstrasse 111, CH-3072 Bern, Switzerland

**Summary.** A total of 26 psychiatric inpatients (5.8% of all admissions) in an intensive treatment unit were identified as problem patients by nursing personnel. Reasons for such identification were behavioral pathology of the patient, difficulties of the staff in the relationship with the patient, and insufficient therapeutic progress, and the use of inappropriate therapeutic methods. Compared with a control group, the problem patients were psychotics or personality disorders. They presented more behavioral pathology, were prescribed more medication, and experienced decisively longer hospitalizations, although they profited less from their hospitalization. Follow-up investigation revealed that the majority did not earn their own living, otherwise they were no more poorly socially adapted than the discharged controls. The suicide proneness of problem patients was high. In the treatment of these patients the necessity of adapting the therapeutic standards and expectations is of the utmost importance.

**Key words:** Problem patient – Psychiatric inpatients – Patient-staff-relationship – Behavioral pathology – Follow-up

## Introduction

At least one-third of all general hospital patients are considered by their treating physicians to be problem patients (Nordmeyer et al. 1982). McGaghie and Whitenack (1982) summarized the most frequently indicated characteristics of these patients. Von Mering and Earley (1966) stated that the problem patient using a career in illness as a problem solving process, is essentially untreatable, and Schuller (1977) pointed out the necessity to view the problem patient problem as a patient-physician relationship problem.

Much less work has been done as far as a patient treated primarily in some kind of a psychiatric setting is concerned. Ekdawi (1967) compared a group of the most difficult and of the least difficult psychiatric inpatients. Among the most difficult patients there were more overactive, attention-demanding, explosive, noncooperative, and antisocial psychopaths; among the least difficult patients there were more indecisive and withdrawn psychotics with difficulties in asserting themselves. Neill (1970) examined difficult psychiatric outpatients: compared with controls, they were more frequently diagnosed as psychosis or personality disorder, had more previous hos-

pitalizations, and they were also perceived as more demanding. Apart from these two empirical studies, conclusions drawn from nonsystematic clinical observations have been reported. Groves (1978) ascribed the variety of behavior that problem patients present to their profound dependency needs. Burnham (1966) saw the behavior pathology of these patients to be a function of appeal, provoking intense and divided reactions in the treating team. On the one hand, Chrzanowski (1980) referred to “obstructionist activities of the patient” and Neill (1970) to “perverse attributes”, whilst, Wilmer (1968) stated “the troublesome problem patient often suffers from an iatrogenic disorder”, namely “the failure to empathize” on the part of the therapist. According to Lorber (1975) there are two types of problem patients: the first kind seems to be deliberately deviant, the second responds with troublesome behavior to an extraordinary situation beyond his control.

As we are confronted from time to time with patients who are labeled as problem patients by various members of the staff, we decided to investigate this phenomenon. We were interested in the frequency and the reasons for such a labeling as well as in the possible differences between problem and non-problem patients during their hospitalization and after their discharge.

## Methods

The investigation was carried out in one of the intensive treatment units of the clinic; patients of all diagnostic categories are admitted to the unit, the work of which is characterized by short hospitalization times, high turnover of patients and crisis intervention orientation. We decided to let problem patients be identified by members of the nursing staff. They spend more time with patients than anybody else, they interact more intensively with them, and are also more affected by their behavioral pathology.

Each of the 8 fully qualified members of the nursing team was asked to indicate all those patients he met on the unit that he considered to be problem patients since its constitution 1.5 years ago. A total of 27 problem patients were identified in this way. However, due to fluctuation in the nursing team not all identified patients were known to all orderlies and nurses participating in the enquiry. On average every identified patient was known to  $5.6 \pm 1.4$  members of the team and in every case a patient was known to at least 3 members of the nursing team.

*1. Inquiry Among the Treating Personnel.* In the next step, each of the 8 members of the nursing team was given the names of all the 27 identified problem patients and asked to answer for each patient known to him two questions: (1) did you consider this patient as a problem patient? (2) if so, why? In the interest of obtaining as much information as possible, an open-ended form was used for the second question. One patient was considered to be a problem patient by one member of the nursing team only; this patient was excluded from the study. In each of the remaining 26 patients, at least 2 members of the team agreed independently on the identification. The same two questions were further given to the physicians (10 psychiatric residents) who were in charge of the 26 identified problem patients. Every physician evaluated his own patients only. Altogether 149 inquiry forms were obtained from the members of the nursing team, and 30 inquiry forms from the physicians (4 patients were treated by 2 physicians consecutively). After surveying the answers, 12 groups of possible reasons for the problem patients' identification were constructed. The individual reasons indicated by members of the team, as well as by physicians, were thereafter classified accordingly. Three raters performed the analysis of the answers and classified the reasons into the appropriate groups; agreement among at least two of them was required for the specification to be considered valid. When no agreement was achieved, the statement was classified as "others" (nonclassifiable data). The members of the nursing team indicated 388 reasons in 149 answers; thus on average 2.6 reasons were enumerated by each member of the team for every patient. The physicians specified 73 reasons in 30 answers; thus on average 2.4 reasons were enumerated by each of the physicians for every patient.

*2. Analysis of the Clinical Records.* A control group of 26 patients was constituted. They were all hospitalized in the same unit, and were matched with the problem patients as to the date of their hospitalization; otherwise they were chosen by a random procedure. The clinical records of the problem, and the control patients were then scrutinized in the same manner, the topics of interest being the personal, the clinical, and the treatment data. Clinical charts give information of sufficient reliability and validity provided they are properly kept (Csernansky et al. 1983). Our clinical charts are generally of a good quality. In order to ensure their reliability the patient personal data taken from the charts were checked during the follow-up investigation and were found to be correct. In all parts of the chart review, only unequivocal statements were taken into consideration.

*3. Follow-up Investigation.* As the last part of our explorative study, a follow-up investigation was performed, covering the period of 2 to 3.5 years following the index discharge of the patient from the unit. Between the problem patients and the control group there were no significant differences as to the length of the follow-up period. During this follow-up investigation attention was primarily paid to three areas: (1) the re-hospitalization frequency of the patients. For this purpose all German-speaking psychiatric institutions of the Canton of Berne were contacted. (2) Suicide frequency among the patients. For this purpose the archives of the Police Department of the town and the Canton of Berne were scrutinized. As every suicide in the Canton of Berne has to be reported to the police, the police files contain the most complete registration of suicides available. (3) The psychosocial adaptation of the

patients as far as the areas of work, living arrangements, financial situation, adequacy in personal issues and interpersonal contacts (at work and at home) and the utilization of the psychiatric outpatient services are concerned. For this purpose, a questionnaire was constructed, covering all these areas, and it was completed on the basis of a semistructured interview carried out with the discharged patients. In the questionnaire, objective data only were asked and evaluated.

*4. Statistical Evaluation.* The results were evaluated using two tailed *t*-test and  $\chi^2$ -test. Fisher's exact test was used where necessary. Rank correlation (Kendall) was determined to compare the statements indicated by nurses and physicians.

## Results

A total of 26 patients were identified as problem patients by the independent judgement of at least 2 members of the nursing team. In fact, in 21 patients 4 or more members of the nursing team agreed on that identification. During the same period of time, 445 patients were admitted to the unit; thus, the proportion of problem patients was 5.8% of all admissions. On average, each of these 26 problem patients was known to  $5.7 \pm 1.3$  members of the nursing team, and  $5.0 \pm 1.5$  members considered the patient to be a problem patient. Of 149 judgements made by the nursing staff members, 130 (87%) were in favor of defining the patients as problem patients, this figure representing a high degree of agreement. As far as the estimates of the physicians are concerned, for 6 patients (= 23% of the patients), the physician did not consider his patient to be a problem patient. Taking all estimates (those of the members of the nursing team and of the physicians) together, in 11 patients (42%) there was unanimous agreement with the definition of problem patient among all those who knew the patient. In only 3 patients (12%) was the corresponding agreement less than 70%.

### *1. Inquiry Among the Treating Personnel*

Table 1 presents the 12 classes which were formed in order to classify the statements regarding the reasons for the designation of the patient as a problem patient along with the classification of all statements. The statements were relatively equally distributed among most of the classes, and there was no clear predominance of 1 particular class. Several major groups of statements can be constructed: The first group encompassed classes 1 to 5, and covered various forms of behavioral pathology of the patient, in which 59% of the statements of the members of the nursing staff and 51% of all statements made by the physicians belonged to this group. The second group encompassed classes 7 and 8 and reflected the inner reactions of the therapists to the patient. In this case 18% of the statements made by both the members of the staff and the physicians belonged to this group. The third group (classes 6, 9 and 10) with 20% and 19% of all statements respectively was related to the treatment of the patient and his therapeutic progress. The last group encompassed classes 11 and 12 and contained statements, which can hardly be considered to be "reasons" in a proper sense, and nonclassifiable statements. The distribution of the statements among the four groups for the individual raters was relatively equal. The majority of the patients were characterized by statements from all four

**Table 1.** Classification of 388 statements of members of the nursing team and of 73 statements of physicians regarding reasons for considering a patient being a problem patient (percentages in brackets)

	Nursing staff (pool of 388 statements)	Physicians (pool of 73 statements)
1) Aggressive behavior (attacks against staff and/or fellow patients, damage to property)	30 (7.7)	7 (9.6)
2) Open resistance (patient breaks the rules of the house, manipulates other patients in a destructive way)	63 (16.2)	9 (12.3)
3) Passive behavior (patient withdraws, does not participate in therapy; misuses the institution playing a "hotel guest")	43 (11.1)	5 (6.8)
4) Suicidal behavior (suicidal threats, trials, suicide)	9 (2.3)	6 (8.2)
5) Other problematic behavior (patient is elusive, unreliable, unpredictable, uncanny)	54 (13.9)	10 (13.7)
6) Resistance to therapy (persistence of psychopathology, hospitalization gets too long, relapse)	46 (11.9)	10 (13.7)
7) Relationship problems on the part of the therapist (therapist cannot empathize with the patient, does not understand him)	23 (5.9)	6 (8.2)
8) Frustration of the therapist (therapist feels overstrained, helpless, uncertain, exhausted, aggressive)	48 (12.4)	7 (9.6)
9) Mistakes of the therapist (use of incorrect/insufficient therapy)	28 (7.2)	3 (4.1)
10) Use of "unpopular/questionable" methods (ECT, seclusion)	4 (1.0)	1 (1.4)
11) Some life events of the patient indicated as explanation for his behavior	15 (3.9)	2 (2.7)
12) Others (nonclassifiable data)	25 (6.4)	7 (9.6)

**Table 2.** Comparison of problem and control patients with regard to some personal variables, illness-related variables and diagnosis (percentages in brackets)

		Problem patients ( $n_1 = 26$ )	Control patients ( $n_2 = 26$ )	Significance
Sex	♂	11 (42)	14 (54)	N.S.
	♀	15 (58)	12 (46)	
Average age	years	31.5 ± 11.0	37.6 ± 14.1	N.S.
Marital status	single	14 (54)	14 (54)	N.S.
	married	7 (27)	7 (27)	
	divorced/widowed	5 (19)	5 (19)	
Educational level	primary school or less	11 (42)	6 (23)	N.S.
	more than primary school	15 (58)	20 (77)	
Average duration of psychiatric illness (years)		6.7 ± 6.2	7.9 ± 12.0	N.S.
Average number of psychiatric hospitalizations (including index hospitalization)		4.3 ± 2.8	4.0 ± 3.9	N.S.
Total average time spent in psychiatric institutions (days)		500.7 ± 577.0	227.8 ± 349.4	$P < 0.05$
Average duration of index hospitalization (days)		70.4 ± 64.7	18.8 ± 16.9	$P < 0.001$
Cause of index hospitalization	dangeours towards self and/or others	11 (42)	9 (35)	N.S.
	other causes	15 (58)	17 (65)	
Diagnosis	Schizophrenia	8 (31)	5 (19)	$P < 0.05$
	Affective disorders	6 (23)	4 (15)	
	Personality disorders	11 (42)	8 (31)	
	Others (reactive disorders, organic psychoses, alcoholism)	1 (4)	9 (35)	

groups. There was a significant correlation of 0.61 between the statements made by the members of the nursing team and by the physicians ( $P < 0.01$ ).

## 2. Analysis of the Clinical Records

The data of the problem patients were compared with the corresponding data of the controls. Table 2 to 4 present the results of this comparison. As Table 2 shows, there were no significant differences between both groups as to the patients' sex distribution, age of educational level. Problem patients differed significantly from the controls as far as their diagnost-

ic distribution was concerned. The group of problem patients was constituted almost exclusively by psychotics, and by patients with personality disorders, the group of controls showing a much broader diagnostic spectrum. Excluding the diagnostic group "others" there were no more significant diagnostic differences between the problem and the control patients. There was a substantial difference in the average duration of the index hospitalization, which was more than three times longer in the problem patients. The same difference also applied to previous hospitalizations: they were comparable in number, but of a substantially longer average duration. This result was substantiated even when the diagnostic group

**Table 3.** Comparison of problem and control patients with regard to the biological treatment they received during index hospitalization (percentages in brackets)

	Problem patients ( $n_1 = 26$ )	Control patients ( $n_2 = 26$ )	Significance
Treated with neuroleptics (NL)	23 (88)	16 (62)	$P < 0.05$
Treated with antidepressants (AD)	10 (38)	4 (15)	N.S.
Treated with tranquilizers (Tr)	12 (46)	8 (31)	N.S.
Treated with NL only or AD only or Tr only	7 (27)	13 (50)	N.S.
No psychopharmacological agents	2 (8)	6 (23)	N.S.
Parenteral medication	12 (46)	4 (15)	$P < 0.05$
Average number of PRN applications	$2.6 \pm 2.2$	$1.5 \pm 1.2$	$P < 0.05$
Treated with ECT	2 (8)	0 (0)	N.S.

**Table 4.** Comparison of problem and control patients with regard to some behavioral patterns they presented during index hospitalization and with regard to their condition on discharge. Data based on an evaluation of the charts (percentages in brackets)

	Problem patients ( $n_1 = 26$ )	Control patients ( $n_2 = 26$ )	Significance
Suicidal behavior (thoughts, threats, trials, suicide)	7 (27)	1 (4)	$P < 0.05$
Aggressive behavior	13 (50)	4 (15)	$P < 0.01$
Uncooperativeness	16 (62)	2 (8)	$P < 0.001$
Demanding behavior	4 (15)	1 (4)	N.S.
Lack of contact, withdrawal	10 (38)	3 (12)	$P < 0.05$
No general amelioration on discharge <sup>a</sup>	9 (36)	3 (12)	$P < 0.05$

<sup>a</sup>  $n_1 = n_2 = 25$  for this variable: 1 problem patient committed suicide during his hospitalization, 1 control patient not evaluated because of the lack of the data

“others” was excluded from the analysis. Thus, this finding cannot be accounted for by the difference in the diagnostic distribution.

As far as medication is concerned (Table 3), more problem patients received neuroleptics. Problem patients required a higher average number of PRN applications and they also required parenteral medication more frequently. All these differences remained statistically significant even after the diagnostic group “others” was excluded from the analysis.

The problem patients presented more frequently each of the types of behavioral pathology described in the clinical records and investigated (Table 4): the differences between both groups were statistically significant for most cases. In addition, the problem patients profited significantly less from their index hospitalization. Excluding the diagnostic group “others” from the analysis there were no differences between the problem patients and the controls as to the variable “lack of contact, withdrawal”, and also the variable “suicidal behavior” did not reach the level of statistical significance ( $P < 0.08$ ); apparently, the differences in these variables can be explained –

partially for the suicidal behavior – by the differences in the diagnostic distribution.

### 3. Follow-up Investigation

In total 15 (58%) problem patients were rehospitalized during the follow-up period of 2 to 3.5 years duration. These 15 patients experienced 33 psychiatric rehospitalizations and they spent on average  $55.3 \pm 117.4$  days in the hospital per rehospitalization. The comparable numbers for the controls were 15 (58%) rehospitalized patients who experienced 37 rehospitalizations during the follow-up period of the same duration. The average duration of a rehospitalization for the controls was  $40.4 \pm 65.6$  days, thus being insignificantly shorter.

Apart from 1 problem patient who committed suicide while on the hospital register, 2 other problem patients committed suicide during the follow-up period, 3 and 9 weeks after their discharge respectively. No suicide was registered among the controls.

The follow-up interview was performed in 18 problem and 15 control patients; 3 problem and 7 control patients refused to participate in the interview, 5 problem patients and 4 control patients could not be interviewed because of various reasons (death, moving into another city or country, failure to trace the patient).

The results are summarized in Table 5. With the exception of the item “financial situation” there were no significant differences between the problem and control patients with respect to their postdischarge psychosocial adjustment. Less than one-third of the problem patients fully earned their own living, compared with two-thirds of the controls. A high number of 11 problem patients (61% of all problem patients participating in the follow-up study) had a pension, this in spite of their relatively young average age. Only 4 (27%) of the corresponding controls had a pension – the difference between both groups was statistically significant ( $P < 0.05$ ). There was no significant difference between the two groups as to the number of patients attending outpatient services or taking medication at the time of their follow-up. Removing the patients of the diagnostic group “others” from the analysis changed none of the results presented in Table 5, with the exception of the item “financial situation”: the difference between both groups became statistically even more pronounced ( $P < 0.01$ ).

### Discussion

The whole issue of a psychiatric problem patient is insufficiently explored and a precise definition is lacking. As no workable definition of a problem patient was primarily available in this explorative study, the identification of problem patients by retrospective patient evaluation by members of the nursing team was necessarily subject to bias. Owing to the identification procedure used, some patients who might have been considered to be problem patients during their hospitalization were possibly missed in our inquiry. In contrast, the high degree of agreement among the personnel at independent evaluations makes the false identification of a patient as a problem patient quite improbable. On the other hand, we felt that the introduction of arbitrary inclusion and exclusion criteria could in an undesirable way limit the scope of our

**Table 5.** Comparison of problem and control patients with regard to postdischarge psychosocial adjustment. Evaluation based on follow-up interview (percentages in brackets)

		Problem patients ( $n_1 = 18$ )	Control patients ( $n_2 = 15$ )	Significance
Occupational situation	Working regularly	6 (33)	6 (40)	N.S.
	Working irregularly	8 (44)	7 (47)	
	Not working	4 (22)	2 (13)	
Living situation	Alone	5 (28)	7 (47)	N.S.
	With relatives/family	10 (56)	5 (33)	
	In institution/no place of residency	3 (17)	3 (20)	
Financial situation	Earns his own living fully	5 (28)	10 (67)	$P < 0.05$
	Pension/no income	13 (72)	5 (33)	
Competence in personal issues	Fully competent in all 7 areas investigated	8 (44)	8 (53)	N.S.
	Not competent	10 (56)	7 (47)	
Competence in interpersonal contacts	Competent in both areas investigated	10 (56)	8 (53)	N.S.
	Not competent	8 (44)	7 (47)	
Utilization of outpatient services	In outpatient treatment	11 (61)	9 (60)	N.S.
	Taking medication	13 (72)	9 (60)	N.S.

open exploration, and also, that the subjective factor can probably never be eliminated totally, being possibly a very part of the problem patient concept and always playing a role in the problem patient identification process; the latter has in fact been at least to some extent confirmed by our results.

The controls were matched to our index cases as to the date of their hospitalization exclusively. This was intentionally done so as not to miss any possible differences between the groups. The differences in the variables such as sex, age, and diagnosis may confuse the real meaning of other findings. However, both groups did not differ from each other as far as sex and age were concerned, and we tested all our results with regard to their possible dependence on the differences in the diagnostic composition of both groups.

A total of 26 patients were identified as problem patients during a period of 1.5 years, this figure corresponding to 5.8% of all admissions to the unit. This proportion seems to be much smaller than that observed in general hospitals; the threshold for considering a patient as an especially difficult patient is obviously higher in psychiatrically trained personnel. Among the members of the nursing team, there was very good agreement regarding the identification of problem patients based on independent evaluations. This corresponded well with their efforts to work as a team; the members of the team share certain values and attitudes. In almost every fourth patient, the treating physician did not agree with such an identification; quite clearly the physician does not see the patient in the same way the nurse does. However, the reasons indicated by the nursing personnel and by physicians regarding the problem patient identification correlated closely with each other. Thus, it may only be quantitative distinctions that account for the difference.

Various forms of behavioral pathology like aggressive, suicidal, and manipulative behavior are often enumerated as reasons for considering a patient to be a problem patient. The presence of such behavior was confirmed by independent investigation of the charts, and it may indeed make it more difficult to treat such patients. According to Vlasak (1975) the

sick role grants certain exemptions and rights but confers upon the affected person certain obligations: to recognize and treat the sick state as undesirable, to cooperate and to want to get well as soon as possible. Many other psychiatric patients may, however, not comply with this defined sick role, e.g., suicidal or psychotic patients. Such cases are not all necessarily considered as problem patients. The time factor will be of great importance here, the noncompliance of nonproblem patients with such defined sick role being of a short duration only. The behavioral pathology mentioned makes it difficult to find a desired positive accepting attitude towards the patient, and may on the contrary evoke feelings of frustration in the "helpless helpers". The development of such "nontherapeutic" feelings in the therapist is often well reflected. However, sometimes the patient is probably considered to be a problem not because of his individual disturbing behavioral pathology or disturbance which, being of a quantitative nature only, would prompt the use of normative rather than psychological evaluation criteria (Cumming and Cumming 1956), but because he does not get better clinically to the extent or as rapidly as the therapist expects, or because the therapist starts blaming himself for not having used the most appropriate methods of treatment. Michels (1977) assumed that the therapist's sense of difficulty regarding the patient may coincide with therapy failure. Apparently, in these instances, it is not really the behavioral pattern of the patient, but too high expectations of the therapist regarding the course and the outcome — and in this respect there seems to be no difference between the members of the nursing team and physicians — which may substantially contribute to labeling the patient as a problem patient.

As in the psychiatric outpatients in the study of Neill (1970) our problem patients were also predominantly psychotics or personality disordered patients. In addition, there were some other substantial differences between our problem and non-problem patients. Our problem patients more frequently received medication, and were given more PRN and parenteral applications. Furthermore, in these patients a tendency

towards polypharmacy was observed. These findings reflect the difficulties in the management of problem patients due to their abnormal behavior, but also the limitations the staff experiences regarding the use of alternative treatment methods or the building-up of a trusting therapeutic relationship. Administration of a medication can be a relationship-equivalent (Gutheil 1978). Overlapping or unnecessary prescription for medication was noted by Neill (1970).

The most significant difference between the two groups was the substantially longer average duration of the index and of the previous hospitalizations of the problem patients. There are some primarily personality disordered borderline patients who react to hospitalization by behavioral regression (Adler 1973), and some of our problem patients might belong to this category. There is no evidence that the behavioral regression is of any benefit in such patients (Friedman 1969), but this regression may in a decisive manner prolong the hospitalization unless very incisive steps such as enforced discharge are undertaken. On the other hand, some patients may require a longer hospitalization (Rabiner and Lurie 1974); their not progressing steadily or quickly enough and thus not fulfilling the implicit expectations of the therapist may again prompt the labeling process in these patients. Even these patients may present a pronounced behavior pathology, which in turn may be at least partially a reaction to the therapist's failure to recognize the basic inability of the patient to meet the therapist's expectations. In spite of their substantially longer hospitalization problem patients profited less from it: 36% of them were no better at the time of their discharge than on their admission. In some of them a short hospitalization might have been the appropriate measure; in some the indication for hospitalization might have been wrong. In others, however, the therapy they needed failed: one patient committed suicide while still in hospital, two others soon after discharge. Compared with the controls, those who commit suicide after their discharge frequently have case notes indicating a disturbed hospital relationship, and are often considered overdemanding and uncooperative (Flood and Seager 1968). Two-thirds of the patients who committed an institutional suicide had been experienced by the staff as difficult or troublesome (Niskanen et al. 1974). Such patients can hardly be considered as being simple trouble-makers.

The follow-up investigation revealed that at least in one respect, the problem patients were more handicapped than the controls. The majority did not earn their own living. Over 60% of the problem patients who could be contacted for the follow-up investigation had a pension despite their average age of 29.5 years. Otherwise, no differences in various aspects of their social adaptation could be found. Thus, the problem patients did not seem to be problematic to the same extent outside the hospital as they were inside. This finding should be remembered when considering the admission as well as the discharge of such patients. It also underlines the interpersonal dimension in the problem patient labeling process.

Technical advice on how to take care of various types of problem patients are available (di Bella 1979; Fisch 1981; Safirstein 1972). They all stress the importance of setting limits and of constant self-monitoring. A high degree of self-awareness and paying constant attention to the interpersonal exchange between the therapist and the problem patient is the key to the management of a difficult patient (Steiger 1967).

Our data, while confirming this, also indicate the importance of the ability of the therapist to recognize the real degree of suffering of the patient, even if disguised by the negative behavioral pathology; and the importance of the ability to recognize that the generally accepted standards and expectations might not be appropriate in some cases, and to allow for exceptions when necessary.

## References

- Adler G (1973) Hospital treatment of borderline patients. *Am J Psychiatry* 130:32-36
- Burnham DL (1966) The special-problem patient: victim or agent of splitting? *Psychiatry* 29:105-122
- Chrzanowski G (1980) Problem patients or troublemakers? Dynamic and therapeutic considerations. *Am J Psychother* 34:26-38
- Csernansky JG, Yesavage JA, Maloney W, Kaplan J (1983) The treatment response scale: A retrospective method of assessing response to neuroleptics. *Am J Psychiatry* 140:1210-1213
- Cumming J, Cumming E (1956) Affective symbolism, social norms, and mental illness. *Psychiatry* 19:77-85
- Di Bella GAW (1979) Educating staff to manage threatening paranoid patients. *Am J Psychiatry* 136:333-335
- Ekdawi MY (1967) The difficult patient. *Br J Psychiatry* 113:547-552
- Fisch HU (1981) Der Umgang mit dem "schwierigen" Patienten. *Schweiz Rundschau Med (PRAXIS)* 70:1233-1235
- Flood RA, Seager CP (1968) A retrospective examination of psychiatric case records of patients who subsequently committed suicide. *Br J Psychiatry* 114:443-450
- Friedman HJ (1969) Some problems of inpatient management with borderline patients. *Am J Psychiatry* 126:299-304
- Groves JE (1978) Taking care of the hateful patient. *N Engl J Med* 298:883-887
- Gutheil TG (1978) Drug therapy: alliance and compliance. *Psychosomatics* 19:219-225
- Lorber J (1975) Good patients and problem patients: conformity and deviance in a general hospital. *J Health Soc Behav* 16:213-225
- McGaghie WC, Whitenack DC (1982) A scale for measurement of the problem patient labeling process. *J Nerv Ment Dis* 170:598-604
- von Mering O, Early LW (1966) The diagnosis of problem patients. *Hum Organization* 25:20-23
- Michels R (1977) Treatment of the difficult patients in psychotherapy. *Can Psychiatr Assoc J* 22:117-121
- Neill JR (1970) The difficult patient: identification and response. *J Clin Psychiatry* 40:209-212
- Niskanen P, Lönnqvist J, Achte K, Rinta-Mäntä R (1974) Suicides in Helsinki psychiatric hospitals in 1964-1972. *Psychiatria Fennica* 275-280
- Nordmeyer J, Steinmann G, Deneke FW, Nordmeyer JP, van Kerkjarto M (1982) Verbale und nonverbale Kommunikation zwischen Problempatienten und Ärzten während der Visite. *Med Psychol* 8:20-39
- Rabiner CJ, Lurie A (1974) The case for psychiatric hospitalization. *Am J Psychiatry* 131:761-764
- Safirstein SL (1972) The clinging patient - a serious management problem. *Can Psychiatr Assoc J* 17 (Special Supp. 2):221-225
- Schuller AB (1977) About the problem patient. *J Fam Pract* 4:653-654
- Steiger WA (1967) Managing difficult patients. *Psychosomatics* 8:305-308
- Vlasak GJ (1975) Medical sociology. In: Perlin S (ed) *A handbook for the study of suicide*. Oxford University Press, New York London Toronto, pp 131-146
- Wilmer HA (1968) Doctor-patient relationship and the issue of pity, sympathy, and empathy. *Br J Med Psychol* 41:243-248

Received May 30, 1985