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The Difficult Patient

By M. Y. EKDAWI

It is usual to encounter, in any large mental hospital, a group of patients who are considered by the staff to be difficult. This opinion is slowly formed, but, once established and repeatedly expressed in nursing reports and medical records, it rarely alters and may have a powerful influence on the patient's career in hospital. A difficult patient may find himself deprived of privileges and moved to a "lower level" ward (9, 10, 11) and his demotion in this way can affect his relatives' attitudes towards him (17). On the other hand, patients informally classified by the staff as "good patients" may be granted certain advantages and, as Cohen put it, "if they behave okay, they move to a better billet" (5).

These staff opinions are based on the patients' behaviour, and may strongly influence the outcome of their hospitalization (6) and probably their resettlement and post-hospital adjustment.

Various authors have described the difficult patient and his hospital behaviour under different names and guises. Belknap (2) on the "lower level group" patient, stated that he is unco-operative, nagging and delusional; he may be potentially dangerous, and may be given to incontinence and he may subject the staff to incessant pestering. Goffman (9) described certain types of institutional behaviour under the heading of "messing up": these include fighting, drunkenness, attempted suicide, insubordination, homosexuality, improper leave-taking (absconding) and participation in collective riots. The difficult patient may show behaviour which is unexpected and contrary to the norms (15) and his means of communication with members of his group are abnormal (6). Main's "special patient" (12) was a female with a history of self-destructive and aggressive acts and who was sleepless, importuning and commanding of attention; she also had a large number of minor somatic illnesses, and her suffering contained marked sadistic elements.

It is to test some of these hypotheses, and in an attempt to make some objective definitions of what characterizes a difficult patient, that this study has been undertaken.

Selection of Patients

It was decided that selection of patients should be made by members of the nursing staff; this was because patients interact with nurses more than with any other group of hospital staff, and because it is often said that nurses can predict, from patients' behaviour, their chances of successful adjustment outside hospital better than doctors can (6).

As a first step, the nursing administrators were separately invited to make lists of patients they thought were the most difficult in the hospital; nursing administrators are well-acquainted with ward management problems and they are invariably involved in patient transfers. Two groups of patients were excluded at the outset: geriatric patients, since they pose special problems, and newly admitted patients because they are an "unknown quantity"; time being a crucial factor in defining deviance (6), a new patient has not yet acquired a reputation. The senior nurses in charge of patients chosen by the administrators in turn made their own individual lists of the most difficult patients in their wards. A final list was prepared by omitting names not listed by at least two staff members. Only a few patients were in fact excluded, as there was a remarkable measure of agreement in the lists. It was, incidentally, noticeable that male nurses were more reluctant to classify many of their patients as difficult than female nurses. The final list numbered 23 patients (8 men and 15 women).

As a contrast, the same nurses compiled lists

of patients who were least difficult. Although these lists contained many more names, there was less agreement and the resulting group consisted of 22 patients (5 men and 17 women).

Method

Two senior nurses on each of the wards independently rated their most difficult and least difficult patients on the Fergus Falls Scales (14) and the Venables' Modification of the Lorr Scales (19). Every patient was also rated by the author on the Wittenborn Scales (21) and the Check-List of Psychiatric Symptoms (16). Brief summaries were made from the patients': case records, noting behaviour abnormalities. Finally, the nurses were asked to describe features of attitudes and behaviour which they thought to be the attributes of the difficult patient.

Results

The statistical significance of differences between the most difficult and least difficult groups in their distributions on the various ratings and attributes was, in general, determined by reducing all distributions to two by two form, where necessary using more than one split, and testing the significance of differences either by chi-squared or, where expected numbers were below five, by Fisher's exact method. As the distribution *most difficult* versus *least difficult* was constant, a special table was constructed from which the significance of differences could be rapidly read off.

The significance level is indicated in the remainder of the article and in the tables by the following abbreviations:

The most difficult group are denoted by the abbreviation MD and the last difficult by the abbreviation LD.

Probability	*Verbal description*	*Abbreviation*
$=$ $<\cdot10$ $>\cdot05$	?significant	?S
$=$ $<\cdot05$ $>\cdot01$	significant	S
$=$ $<\cdot01$ $>\cdot001$	very significant	VS
$=$ $<\cdot001$	very, very significant	VVS

Diagnoses

There were more psychopaths (S) in the most difficult (MD) group than in the least difficult (LD) group. The latter, on the other hand, contained more paranoid schizophrenics (S). Other diagnoses were present, but not predominantly in either group.

Transfers

The two groups were compared as to mean number of ward transfers by analysis of covariance, allowing for the regression of number of transfers on the time exposed to risk of transfer (i.e. duration of stay in hospital). The results are set out in Table I. The MD group had many more ward transfers (VVS) than the LD group, and this was in accordance with Frank's findings (8). There was, however, only a slight preponderance of MD patients in the more closely supervised wards, and no evidence for the concept of ward "demotion".

Table I

Transfers: Analysis of Covariance, Regression on Time at Risk

Source of Variation	df	Errors of Estimate: Sum of Squares	Errors of Estimate: Mean Square
Total	44	3768·9	
Groups	1	1064·4	1064·4
Error	43	2704·5	62·9

$F = 16\cdot92$, df 1 by 43, $p < \cdot001$

A. *Duration of time in Hospital in Months*

Patients	Mean	Range	Standard Deviation
MD	8·9	2–26	6·5
LD	11·6	2–26	6·4

B. *Number of Transfers in Hospital*

Patients	Mean	Range	Standard Deviation
MD	16·1	3–51	11·0
LD	9·2	2–24	6·1

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Symptoms and Behaviour Abnormalities

There were statistically significant differences in 5 out of 15 comparisons. More of the MD patients showed psychopathic trends (VS), self-mutilating behaviour (S) and drug addiction (S). More LD patients absconded (S) and were either physically ill, badly treated by their families or injured by other patients (VVS).

Symptom comparisons showed that more MD patients had manic trends (S), hysterical, aggressive and anti-social trends (VVS), homosexuality and other sexual deviations (VVS). More LD patients, on the other hand, had delusions (S), hallucinations (?S) and thought disorder (VVS). They also showed volitional disturbance (S) and motor disturbance (?S). The total number of symptoms shown by MD patients exceeded that shown by LD patients.

Wittenborn Scales (Table II)

A more detailed picture of the MD patient emerges from the ratings. He is overactive and has difficulty in sleeping without sedation. He seems unaware of the feelings of others, and at the same time he feels misunderstood and persecuted. He is extremely attention-demanding and he often complains of physical symptoms. His opinions are strongly held and forcefully expressed; his speech is pedantic and his voice carries. Although he may be optimistic, his mood fluctuates, and he may threaten or attempt suicide. He has an explosive temper and he indulges in distortions, lying, stealing and homosexual behaviour.

The composite profile of the LD patient is of a slow, indecisive and withdrawn person, who had difficulty in asserting himself. His affective responses are blunted and his thinking is bizarre or obscure. He may be very paranoid or not at all.

Ward Behaviour (Tables III and IV)

There was no significant difference between the two groups in their tidiness and attention to dress and personal apperance, nor did they differ in their table manners, toilet behaviour or attitude to and performance at work.

The MD patient is energetic, very talkative, generally sociable and interested in his surroundings, as well as in newspapers, wireless and television programmes and social activities to a much greater degree than the LD patient, although he actually participates less in social functions. Finally, the MD patient is less co-operative towards the nurses and probably less co-operative towards doctors, psychologists and social workers than the LD patient.

Case Records

Various descriptive phrases and adjectives recur regularly in the medical case records of MD patients. These are: hostile, aggressive, noisy, destructive, resistive, unco-operative, unreliable, demanding and unpredictable. Three MD patients were "spiteful" and four were "full of aches and pains". Such descriptions are, according to Goffman (9), just the sort that a layman would consider defamatory and discrediting.

Nurses' Concept

Male nurses used the verb "pester" in their description of MD patients' behaviour more often than female nurses. The majority of the nurses found MD patients argumentative and complaining. Touching, or making unnecessary physical contact as an MD characteristic, was exclusively mentioned by female nurses. This was unexpected, as it is often observable that female nurses tend to touch their patients more than male nurses. In spite of differences in sex, age and cultural background, there was no semantic difficulty; all the nurses had a clear and near-identical concept of what "difficult" meant.

Discussion

One of the functions of a psychiatric hospital is to deal with a large number of patients who, because of their behaviour, could not make satisfactory adjustment in the community. Yet, once in hospital, with a few exceptions, they adjust to the norms of the institution. This adaptation can take various forms (13). It is possible that the adaptation is mutual, that the institution adjusts itself to its patients by developing its special norms which differ from those of the community. Institutional norms are maintained by means of rules, procedures and

TABLE II
(*Wittenborn*)

Variable	MD		LD
1. Sleeping difficulties	VS		
4. Obsessional thinking		NS	
5. Self-blaming behaviour			S
6. Lack of self-assertiveness			VVS
7. Overactivity	VS		
8. Unaware of the feelings of others	VVS		
9. Use made of physical disease symptoms	VVS		
11. Disrupting routines	VVS		
12. Irritability	VVS		
13. Social withdrawal			VVS
15. Phobias		NS	
16. Personal neglect		NS	
20. Optimism	S		
22. Pessimism		NS	
25. Hysterical behaviour	S		
26. Feelings of persecution	VVS		
27. Feelings of reference or influence*			
28. Feelings of anxiety		NS	
31. Demands for attention	VVS		
32. Slowing of response			VVS
33. Grandiose ideas		NS	
34. Lack of insight		NS	
36. Variable rate of speech	VVS		
37. Belligerence	VVS		
40. Suicidal tendencies	VS		
41. Failure of affect			VS
44. Impaired judgment of likelihood	VVS		
45. Perceptual disturbances			S
48. Relevance of words to recognizable ideas			?S
49. Efficiency impaired by anxiety			VS
51. Circumstantial speech	?S		
52. Homosexuality	VVS		
53. Lying and stealing	VVS		
55. Lack of co-operation	VVS		

* Significance here varies according to where the split is made. MD patients have an excess rated at level 2, LD patients at levels 1 and 3 or higher. It would seem that MD group includes a considerable number of mildly paranoid patients, while LD group is mainly composed of patients who are either very paranoid or not paranoid at all.

Total Number of Symptoms Present
(distribution tested by chi-squared)

Patients	Range	Mean	Standard Deviation
MD	22–46	32·0	5·8
LD	12–49	23·2	6·0

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TABLE III
Behaviour Rating Scale

	Variable	MD	LD
A.	Work		NS
B.	Behaviour at meals		NS
C.	Response to other patients		NS
D.	Response to nurses	Less co-operative (S)	
E.1.	Response to PSW, Psychologist and Doctor	Less co-operative (?S)	
F.	Response to treatment	Less accepting (VVS)	
G.1.	O.T.	Less participating (S)	
G.2.	Social activities	Less participating (?S)	
H.	Attention to dress and personal appearance		NS
I.1.	Overactivity	More overactive (S)	
I.2.	Underactivity		More underactive (VVS)
J.1.	Talkativeness	More talkative (VS)	
K.	Toilet behaviour		NS

TABLE IV
Activity-Withdrawal Scale

Variable	MD	LD
1	more active (VS)	
2	more talkative (VVS)	
3	more energetic (VS)	
4	No significant difference in number of friends	
5	more loud voiced (VVS)	
6	more interested in TV, wireless, etc. (VS)	
9	more sociable (?S)	

systems of sanction and reward. In total institutions, as defined by Goffman, these are rigid, detailed and universal, ensuring maximal institutional adaptation, and in such circumstances there may be few "difficult" patients. It is possible that absconding for instance, contrary to the findings of Goffman and others, does not constitute difficult behaviour, since there is a simple set procedure (notifying relatives and/or the police) for dealing with it.

Other important factors in this mutual adjustment are the ideologies prevalent in the hospital and the patients' attitudes to them. Thus, in this hospital, where there has been a strong emphasis on the care and rehabilitation of long-term schizophrenics, the slow, withdrawn, as well as the overtly psychotic are among the least difficult of patients. These findings were also at variance with other studies. The difficult group were less accepting and less co-operative in their attitudes towards the staff (Table III), whereas the amenability of the institutional schizophrenics can be very striking (20).

The role taken by a patient and the staff attitudes to it are also of vital importance. According to Banton (1), not everyone who says he is sick is allowed to play the role of invalid; but once admitted to this role he is exempted from certain social obligations in proportion to the nature and severity of his illness. A psychopath, by being a psychiatric in-patient, claims a definite sick role with all the privileges attached to it, but which he may be denied because of certain staff attitudes to psychopathy (22). These attitudes imply that, whereas a paranoid schizophrenic patient, for instance, is so ill that he cannot help the way he behaves and is therefore fully entitled to his sick role, a psychopath is probably not ill and his behaviour is construed as being difficult and not sick. The sick role also carries some obligations, such as co-operating with those who are trying to help, and the individual who assumes this role without fulfilling its obligations is a difficult patient.

The attitudes of staff involved in this study showed general agreement in direction towards both groups, but there were some important differences which merit further investigation.

Summary

A group of 23 patients, considered by the staff to be the most difficult in a large hospital, were rated on four scales and contrasted with another group (25 patients) said to be the least difficult. From the comparisons, as well as from examination of case records and staff opinions, certain characteristics of the difficult patient were described.

1. The difficult patient shows more psychopathic trends and neurotic symptoms than psychotic features.

2. Attention-seeking, making use of physical symptoms and overactivity, together with unco-operativeness with the staff and a poor response to treatment, were among the distinguishing marks of the difficult patient.

3. The hospital stay of the difficult patient is punctuated by frequent ward transfers.

4. The findings are in general agreement with other work; nevertheless, there were certain marked differences which may be due to prevalent staff attitudes and current ideologies of different hospitals.

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References

1. Banton, M. (1965). *Roles*. London: Tavistock Publications.
2. Belknap, I. (1956). *Human Problems of a State Mental Hospital*. New York.
3. Brown, G. W., Carstairs, G. M., and Topping, G. (1958). "Post-hospital adjustment of chronic mental patients." *Lancet*, *ii*, 685–689.
4. Caudil, W. (1958). *The Psychiatric Hospital as a Small Society*. Cambridge, Mass.
5. Cohen, G. L. (1965). "The sick mind." *New Statesman*, LXX, **1793**, 119.
6. Cumming, J., and Cumming, E. (1956). "Affective symbolism, social norms and mental illness." *Psychiatry*, **19**, 77–85.
7. Folkard, M. S. (1960). "Aggressive behaviour in relation to open wards in a mental hospital." *Ment. Hyg.* (N.Y.), 44, **2**, 155–161.
8. Frank, H. D. (1964). *Patient Distribution in a Mental Hospital*. Ph.D. Thesis, University of London.
9. Goffman, E. (1961). *Asylums*. New York.
10. Jones, K., and Sidebotham, R. (1962). *Mental Hospitals at Work*. London.
11. Kraus, P. S. (1957). "Ward assignment and patient movement in a large mental hospital." In: *The Patient and the Mental Hospital*. Glencoe, Ill.
12. Main, T. F. (1957). "The ailment." *Brit. J. med. Psychol.*, **30**, 129–145.
13. Merton, R. K. (1957). *Social Theory and Social Structure*. Glenco, Ill.
14. Meyer, B. T., and Lucero, R. J. (1953). "A validation study of the L. M. Fergus Falls Behaviour Rating Scale." *J. clin. Psychol.*, **9**, 192–195.
15. Parsons, T. (1957). "The mental hospital as a type of organization." In: *The Patient and the Mental Hospital*. Glencoe, Ill.
16. Robertson, J. P. S. (1962). "Perceptual-motor disorders in chronic schizophrenia." *Brit. J. soc. clin. Psychol.*, **1**, 1–6.
17. Schwartz, C. G. (1957). "Perspectives on deviance—wives' definitions of their husbands' mental illness." *Psychiatry*, **20**, 275–291.
18. Stanton, A., and Schwartz, M. (1954). *The Mental Hospital*. New York.
19. Venables, P. H. (1957). "A short scale for rating activity-withdrawal in schizophrenics." *J. ment. Sci.*, **103**, 197–199.
20. Wing, J. K. (1962). "Institutionalism in mental hospitals." *Brit. J. soc. clin. Psychol.*, **1**, 38–51.
21. Wittenborn, J. R. (1955). *Psychiatric Rating Scales*. New York.
22. Wootton, B. (1956). *Sickness or Sin*. London.

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