



### Araştırma/Research

## Difficult Patient in Psychiatry Practice: A Case-Control Study

Murat Eren Ozen<sup>1</sup>, Mehmet Hamdi Orum<sup>2</sup>, Aysun Kalenderoglu<sup>2</sup>

<sup>1</sup>Private Adana Hospital, Psychiatry Clinic, Adana, Turkey

<sup>2</sup>Adiyaman University Faculty of Medicine, Department of Psychiatry, Adiyaman, Turkey

### Abstract

**Aim:** Some of the patient-physician encounters are considered "difficult" by the relevant physicians. Somatic symptoms, substance abuse, aggression, hostility, and lack of co-operation are the most common features related to difficult patients. That is, the risk of encountering difficult patients in psychiatric practice is high. The difficult relationship may be related to the patient as well as to the physician. We aimed to investigate the difficult patient characteristics associated with the patient in this study.

**Material and Methods:** The difficult relationship is defined as "situations in which the psychiatrist-patient relationship is perceived as problematic". The cases were defined as the difficult relationship with at least two of the psychiatrists who were studying. Controls consisted of patients without difficult relationships. 45 cases and 90 controls were included in the study.

**Results:** There was no significant difference in terms of age, sex, marital status, education status, and working status between the two groups. The number of hospitalization, drugs used, psychotherapy, and social intervention was higher in the case group than in the control group. Personality disorders were significantly higher in the case group.

**Conclusion:** The use of more medicines, more social interventions, more hospital admissions have been attributed to the dissatisfaction of these patients. The improved good therapeutic relationship can lead to fewer symptoms and fewer applications in these difficult patients. Further systematic research should be conducted with respect to the patient-physician relationship to provide a greater understanding of both its etiology and solution.

**Keywords:** Case-Control Study; Difficult Patient; Physician-Patient Relation; Relationship.

### Yazışmadan Sorumlu Yazar

Mehmet Hamdi Örum

Adiyaman Üniversitesi Eğitim ve Araştırma Hastanesi,  
Psikiyatri Servisi, Adiyaman  
Tel : +90 416 216 10 15/1186

Email: [mhorum@hotmail.com](mailto:mhorum@hotmail.com)

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## Psikiyatri Pratiğinde Zor Hasta: Bir Vaka-Kontrol Çalışması

### Kısa Başlık: Psikiyatri Pratiğinde Zor Hasta

#### Öz

**Amaç:** Bazı hasta-hekim karşılaşmaları ilgili hekimler tarafından "zor" olarak kabul edilir. Somatik belirtiler, madde kötüye kullanımı, saldırganlık, düşmanlık ve işbirliği eksikliği, zor hastalarla ilgili en sık görülen özelliklerdir. Yani, psikiyatri pratiğinde zor hastalarla karşılaşma riski yüksektir. Zor ilişki hastaya olduğu kadar hekime de bağlı olabilir. Biz bu çalışmada hasta ile ilgili zor hasta özelliklerini araştırmayı amaçladık.

**Gereç ve Yöntem:** Zor ilişki "psikiyatrist-hasta ilişkisinin sorunlu olarak algılandığı durumlar" olarak tanımlanmaktadır. Olgular, çalışmakta olan psikiyatristlerin en az iki tanesi tarafından zor ilişki olarak tanımlandı. Kontroller bu hekimlere göre zor ilişkileri olmayan hastalardan oluşuyordu. Çalışmaya 45 olgu ve 90 kontrol dahil edildi.

**Bulgular:** İki grup arasında yaş, cinsiyet, medeni durum, eğitim durumu ve çalışma durumu açısından anlamlı bir fark yoktu. Olgu grubunda hastaneye yatış sayısı, kullanılan ilaçlar, psikoterapi ve sosyal müdahale, kontrol grubuna göre daha yüksekti. Olgu grubunda kişilik bozuklukları anlamlı olarak yüksek bulundu.

**Sonuçlar:** Daha fazla ilaç kullanımı, daha fazla sosyal müdahale, daha fazla hastane yatışı zor olarak nitelendirilen bu hastaların memnuniyetsizliğinden kaynaklanabilmektedir. İlerletilmiş iyi bir terapötik ilişki, bu zor hastalarda daha az semptom ve daha az girişimi-yatışı sağlar. Hem etiyojisini hem de çözümünü daha iyi anlayabilmek için hasta-hekim ilişkisine ilişkin daha fazla sistematik araştırma yapılmalıdır.

**Anahtar Kelimeler:** Vaka-Kontrol Çalışması; Zor Hasta; Hekim-Hasta İlişkisi; İlişki

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## Introduction

"Difficult patient" is a well-known figure in everyday mental health services. The term "difficult" refers to the lack of cooperation between the patient and the physician: the patient asks for help and care, but does not immediately accept the offer (1,2). Overall, the proportion of difficult patients comprehended in the total population of inpatient psychiatric patients is estimated at 5-10%; data on overall prevalence are not available and may be difficult to obtain due to the database and allocation in question (3). It is very difficult to define the difficult patient as a group and determine its characteristics. Although psychotherapy studies have progressed significantly, psychiatry has limited efficacy on patients identified as difficult, and this group of patients has been examined according to some clinical criteria (4-6). While most of the authors investigating this issue stressed the importance of the interpersonal approach, they pointed out that there are some more relevant diagnostic categories in this situation (4). Some authors prefer "heartsink" rather than "difficult patient". While Ellis used the phrase "dysphoria" to define the difficult patient, Groves, a psychiatrist, preferred to say "hateful patient" and defined four stereotypes: dependent clingers, entitled demanders, manipulative help rejectors, and self-destructive deniers (7). Physicians describe the most common problems in people they describe as difficult patients: somatic symptoms, mental disorders, alcoholism, substance abuse, aggression, hostility, and lack of co-operation. As it can be seen, the majority of the symptoms are in the field of psychiatry. Difficult patients are a great source of stress for psychiatrists and other mental health staffs (8). Today, this problem is not regarded as a problem only for the patient. Because the personality traits, belief system, and work style of the physician may affect the relationship between them, such as the personality traits of the patient. A feeling of difficulty that arises can lead to a vicious cycle, which leads to a more irrelevant relationship. This mutual interaction has brought the term "difficult relationship" to the fore in the term "difficult patient" (9).

Literature review, despite the frequency and importance of this issue, has made us realize that very little research is being done in our country. Worldwide studies are mostly focused on case studies and theoretical analyses, and there are also very few studies on controlled studies. The tough difficult relationship, sometimes with the doctor, sometimes with the patient, it is necessary to investigate the characteristics of patients who are regarded as difficult by the majority of physicians. This study aims to investigate which diagnoses may be confronted by difficult patients in daily practice.

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## Material and Methods

This is a prospective case-control study that investigated the features of difficult patients (Case group) who were followed in the Psychiatry Department at Adiyaman University Faculty of Medicine with a control group (Patients but not difficult). A common definition of the "difficult patient" in psychiatry does not exist (3). First, the term describes a three-dimensional problematic: [1] The patient is considered to be difficult or difficult from the point of view of the staff working in psychiatry, [2] The patient has difficulties in terms of unfavourable prognosis, poor quality of life and high complication rate, [3] Finally, the patient is burdening society with high costs and impairments of safety and order (3). In a nutshell, "Difficult relationship" is defined as "situations in which the psychiatrist-patient relationship is perceived as problematic, resulting in disappointment, discomfort or dissatisfaction in the treatment process". Based on the above 3 items, we have prepared yes-no questions and defined patients who met all of them as difficult patients. Disorder diagnoses were made according to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (10) by these experimental psychiatrists. Structured Clinical Interview for DSM Disorders II (SCID II) was used to scan the personality disorders. When data were collected, sociodemographic data form and patient records were used. Patient records have been reached that the patient cannot remember. Patients with missing data were not included in the study. Patients who had severe neurological, immunological or systemic diseases were excluded. Cases and controls with risk factors (cancer, pregnancy) that may have an impact on the adjustment of patients were not included. Patients in our psychiatric unit who were treated between 2017 and 2018, under regular control and over 18 years of age were included in the study. The cases were defined as "difficult relationship" with at least 2 of the physicians who were studying. Controls consisted of patients without difficult relationships. In order to make the comparison healthy, two controls were selected for each case. The control group was similarly distributed to the case group in regard to age and gender. SPSS for Windows statistical package version 22 (SPSS Inc., Chicago, IL, United States) was used for all statistical analyses. The numerical data were expressed as means and standard deviations, and the categorical data were expressed as frequencies and percentages. Quantitative variables were analyzed by Student's t-test and categorical variables were analyzed by z-statistic,  $\chi^2$  or Fisher's exact test (95% CI, confidence interval). The risk estimate was calculated by Odds Ratio at 95% confidence intervals (95% CI). A value of less than 0.05 was considered statistically significant. The study protocol was approved by the Adiyaman University Ethics Committee (2018/2-4), and informed consent was obtained from all participants. This study performed in the Declaration of Helsinki.

## Results

45 cases (Males: 22; Females: 23) and 90 controls (Males: 45; Females: 45) were included in the study. The average age of the case group was  $38.9 \pm 13.1$ , the average age of the control group was  $39.9 \pm 11.2$ . There was no significant difference in terms of age, sex, marital status, education status, and working status between the two groups ( $p$  value was  $>0.05$  for all parameters). The comparisons of sociodemographic features of case and control groups are given in table 1.

**Table 1. Sociodemographic Characteristics of Case and Control Groups**

	Case	Control	<i>p</i> value
<b>Sex</b>			
• Male	22 (48.8%)	45 (50.0%)	0.900
• Female	23 (51.2%)	45 (50.0%)	
<b>Age</b>	$38.9 \pm 13.1$ (Minimum: 20, Maximum: 66)	$39.9 \pm 11.2$ (Minimum: 20, Maximum: 64)	0.830
<b>Marital Status</b>			
• Single	27	57	0.910
• Married	12	27	0.910
• Living Together	0	3	0.720
• Divorced	3	0	0.720
• Widow	3	3	0.790
<b>Education Status</b>			
• University	9	16	0.890
• High School	3	9	0.850
• Secondary School	33	56	0.580
• Primary School	0	9	0.530
<b>Working Status</b>	53.3%	70%	0.440

The duration of disease was  $7.9 \pm 6.1$  in the case group and  $7.1 \pm 5.9$  in the control group ( $p=0.600$ ). There were more hospitalizations in the case group but this difference was not significant ( $p=0.880$ ). The mean number of drugs used was  $4.9 \pm 3.2$  in the case group and  $2.7 \pm 1.4$  in the control group ( $p=0.031$ ). The psychotherapy history (only supporting psychotherapy) of the case group was higher than the control group ( $p=0.004$ ). More social interventions (being a member of community mental health center) were needed in the case group ( $p=0.004$ ). The clinical features of the case and control groups are given in table 2.

There was no significant difference between case and control group in terms of axis I, but there was a significant difference in axis II. Axis II frequency was higher in the case group ( $p=0.030$ ). These results are shown in more detail in table 3.

**Table 2. Clinical Features of Case and Control Groups**

	Case	Control	<i>p value</i>
<b>Duration of Diagnosis (Years)</b>	7.9 ± 6.1 (Minimum: 2, Maximum: 26)	7.1 ± 5.9 (Minimum: 1, Maximum: 25)	0.600
<b>Hospitalization</b>	20.0%	14.4%	0.880
<b>Medication (Drug)</b>	4.9 ± 3.2 (Minimum: 1, Maximum: 10)	2.7 ± 1.4 (Minimum: 1, Maximum: 5)	0.031*
<b>Psychotherapy</b>	80.0%	20.0%	0.004*
<b>Social Intervention</b>	51.1%	4.4%	0.004*

\*Statistically significant

**Table 3. Clinical Features of Axis I and Axis II**

	Case	Control	<i>p value</i>
<b>Axis I</b>			
• Schizophrenia	13	19	
• Bipolar Disorder	4	29	
• Others			0.200
• Total	28	42	(Odds Ratio: 0.44 CI 95% 0.12-1.59)
<b>Axis II</b>			
<b>Personality Disorder</b>			0.030*
• Yes	28	23	(Odds Ratio: 4.10 CI 95% 1.1-15.3)
• No	17	67	
• Total	45	90	

## Discussion

The most important implication of this study is that the rate of personality disorder in patients defined as difficult patients is significantly higher. This finding is consistent with the literature (11,12). The use of more medicines, more social interventions, more hospital admissions have been attributed to the dissatisfaction of these patients. The fact that there is no significant difference between axis I diagnose as in our study suggests that these patients should not be evaluated in a particular diagnostic category. This group of cases, who have difficulties in adapting to the situation related to their diseases, also face problems in working life. Our study differs from some studies in the literature by some features. In our study, there is a control group when the control group is not used in the majority of the researches (13,14). Most of the difficult patients in these studies are in the 26-32

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age range. In most studies, difficult patients are predominantly male (15,16). Although it has been stated that difficult patients may be between outpatients (15) and inpatients (14), only one study shows that the frequency of admission of difficult patients to the hospital and hospitalization days is high. This study indicates that there are more difficult patients among the inpatients (17).

The stereotype of dependent clingers in difficult patients appears in especially in patients with psychotic disorders. The stereotype of entitled demanders and manipulative help rejectors are seen in personality disorders. Self-destructive deniers usually have psychotic and personality disorders (7,18). It is thought that physicians working with patients with these challenging characteristics should be more careful to avoid the negative consequences of countertransference (19,20). The improved good therapeutic relationship can lead to fewer symptoms and fewer applications in these difficult patients (6). Although it is known that the difficult patients are followed by which diagnoses, the reason why they are evaluated as heartsink is not clear. The explanations made in this regard are at the theoretical level (21). In our study, it was concluded that this condition was related to personality disorders. The challenge here is not just about treatment. It refers to the difficult situation facing the patient. A good therapeutic relationship affects the patient's caretaking, the willingness to use medication, and the desire to get to the next interview. A poor therapeutic relationship also implies the opposite. From a doctor's point of view; The patient enters the room and the doctor has a pain in her heart or something sits on her stomach (9). Approaches to treating only difficult cases without the judge, like other non-difficult patients, will make them more compatible with the health care system (22). Even though it is accepted that many treatment strategies may be good for a difficult patient with an optimistic outlook (23), there are also those who think that this approach is a narrow viewpoint (24,25).

In conclusion, because of its conceptual structure, the difficult patient is not a new DSM category, but it is a result of the decisions made by the professionals about the patients. When a professional sees a patient as "difficult", he tells how well the patient is in harmony with the role of the ideal patient. Past bad communication and experiences between doctor and patient can prevent the "hard patient" from finding enough answers in search of help even in applications with serious problems. Both patients may be exposed to unfair behavior, ranging from over brownness to negativity due to the resulting relationship. Difficult patients are at risk of unintended consequences if they have real complaints. Most commonly associated with the characteristics of difficult patients are diagnoses from the spectrum of personality disorders. In our study, we mentioned that patients received supportive psychotherapy. However, patients defined as difficult patients need to be treated in different ways. These patients do not see sufficient benefit from drug treatment. In addition to classic learning theory-based procedures, schema therapy and disorder-specific approaches such as dialectic behavioural therapy play a role in borderline personality disorder (26). The future studies on difficult

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patients should focus on the identification, implementation, and evaluation of the interventions to be applied to difficult patients. Future studies should also support both psychological and social-ethical approaches in a conceptual framework (3).

As a limitation of this study, we can talk about the definition of "difficult relationship" which is subjective. We leave the interpretation to the people who will evaluate it so that it is not misunderstood. This fact is specific to the subject studied. The results should be supported by scales that assess the doctor-patient relationship. In this study, only the number of drugs used by the patients was known. New studies can be organized according to the subgroups of drugs. Again, in this study, only the number of personality disorders was known. Further studies can compare the subtypes of personality disorders. On the other hand, another limitation is that the number of patients included in the study is small. The strong thing about this field is that it is a study that has an analytical pattern among those made in the field because it is enough to work on this title.

**Disclosure statement**

No potential conflict of interest was reported by the authors.

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