TAKING ISSUE

Difficult Patients: Within Themselves and With Caregivers

"Difficult patients" may be hard to define, but they are well known in many clinical settings. Although they need and demand help, many ultimately reject it when it is provided. These individuals are identifiable by a combination of diagnostic and functional criteria and their disproportionate impact on the mental health system. In this drama there is a problem of interactive fit: a negotiation between clinician and patient to reach consensus about treatment goals and role performance. The discrepancy between intact functioning and unpredictable maladaptive behaviors leaves caregivers confused, disappointed, and angry. In this issue, the article by Bauke Koekkoek, R.N., C.N.S., and colleagues provides an overview of what is known about difficult patients in mental health care. A focus on patients' behavior can lead to ignoring the impact of the diverse set of values and expectations that clinicians bring to the interaction, which are affected by our theoretical formulation of mental illness, our therapeutic roles, and the treatment settings in which we practice.

Without excusing "bad" behavior, it is useful to understand the existential problems that these patients face. Many suffer from feelings of aloneness or annihilatory panic, having failed to achieve an unshakable sense of self. The self-esteem of these individuals, who struggle with feelings of worthlessness, is crushed by the inevitable ups and downs of everyday life. They will do almost anything to avoid such pain, regardless of the consequences of their "bad" behavior.

So what are we clinicians to do in this struggle for our own sense of professional survival within systems that are ill prepared to provide the extensive long-term services needed? First, do no harm. Having realistic expectations of what can be done can avoid overtreatment, punishment, or abandonment. Second, protect yourself and the patient, for neither you nor the patient can work together if either feels unsafe. Physical and emotional safety must be established for both clinician and patient. Third, help when you can but do not go it alone. It is important to have access to crisis management and containing interventions for the inevitable emergencies. Treat recognizable psychiatric symptoms. Provide or refer patients to supportive interventions to augment the therapeutic relationship. Fourth, heal thyself. Understanding that aloneness and worthlessness are central experiences in difficult patients' lives can counteract the effects of patients' behaviors on the therapeutic relationship. Therefore, it is necessary for us to get consultation, support, and help from others to manage the feelings and behavioral reactions engendered within ourselves.

In the end, this work is long term and requires flexibility and an educational component focusing on the modification of chronic maladaptive behaviors on both sides of the interactive fit.—DAVID A. ADLER, M.D., *professor of psychiatry and medicine, Tufts University School of Medicine, senior psychiatrist, Department of Psychiatry, Tufts New England Medical Center*

Psychiatric Services, established in 1950, is published monthly by the American Psychiatric Association for mental health professionals and others concerned with treatment and services for persons with mental illnesses and mental disabilities, in keeping with APA's objectives to improve care and treatment, to promote research and professional education in psychiatric and related fields, and to advance the standards of all psychiatric services and facilities.