Nurses' Reactions to Difficult Patients

Debra L. Podrasky and Dorothy L. Sexton

The purpose of this study was to determine whom nurses identify as difficult patients and how nurses might react to them emotionally and behaviorally. Participants (N = 73) responded to a self-report questionnaire that contained hypothetical situations involving difficult patients. Frustration and anger were the most common reactions. The traits or behaviors that nurses reported as belonging to the most difficult patients were characteristics that are potentially modifiable. In the majority of cases the nurses' reports of their reactions were classic fight/flight responses.

* * *

Interactions between nurses and patients, like any type of human relationship, at times may have difficulties. These difficulties may stem from a variety of sources, originating with the nurse, the patient, or a combination of these and other factors (Diers, 1964; Ujhely, 1968). Any time there is a threat to the quality or quantity of interactions between patients and nurses, there is a threat to the nursing care that patients receive (Fernicola, 1982; Travelbee, 1971).

Ritvo (1963) asserted that nurses identify patients as being "good" or "bad" patients within the first 24 hours of hospitalization. "Good" patients have such attributes as emotional stability, cheerfulness, controlled feelings and anxiety levels, communicability, appreciativeness, conformity and consideration. In contrast, the "bad" patient is emotionally unstable, highly anxious, depressed, hostile, challenging, overly dependent or independent, aggressive, impatient, unappreciative and nonconforming (Sarosi, 1968). Difficult patients typically consume greater periods of time than their medical diagnosis would suggest and for which the nursing unit is staffed. When patients impede the flow of work with demands, complaints and lack of cooperation or prevent the nurse from carrying out therapies designed for their benefit, they are frequently labelled "difficult" (Orlando, 1961; Ujhely, 1967).

Much of the literature on nurse-patient relationships confirms that nurses are responsible for developing positive relationships (McNellis, 1979; Peterson, 1967; Strauss & Glaser, 1964; Ujhely, 1968). In some cases, a poor nurse-patient relationship may be the fault of nursing, but this is not true in every instance, and conflicts should not be approached automatically from that perspective.

How a person reacts to illness is defined socially, culturally and individually (Hover & Juelsgaard, 1978; Suchman, 1966). When a person enters the hospital, social obligations are left behind and replaced with the new responsibility of being a patient (Keller, 1971; Taylor, 1962). Independence, social responsibility and expressions of identity are taken away (Jaco, 1958; Taylor, 1965) and replaced with a hospital "uniform," an assigned bed and diagnosis (Elms & Diers, 1963). All of these activities serve as a cumulative force to place the person in a dependent, childlike position (Dichter, 1954; Robinson, 1976). Further, while patients are told what is expected of them, they are not told what they can expect from the staff members. The discrepancy between the hospital staff members' and patients' perception of the patient role may add to the problem (Maxson, 1974; Vincent, 1975). A stressful situation such as this may cause personality characteristics to become intensified and exaggerated as basic-level coping mechanisms are employed (Lazarus & Folkman, 1984; Mayou, 1984) in an attempt to restore familiarity and homeostasis (Selye, 1976).

Schwartz (1958) studied 50 patients who had been labelled uncooperative by three or more of the hospital staff. The staff members' reactions could be summarized by the statement "Patients are uncooperative when they make me feel ineffective," and further " . . . when they fail to do my will or have the same goals as I." The patients in the study were uncooperative because they repeatedly made the staff members respond with anger, which made them, as professionals, feel guilty. Highley & Norris (1957) asked 28 junior nursing students from a B.S.N. program to identify what they disliked in patients. The common denominator identified was that patients either made the nursing students feel guilty because of their dislike for the patients or, because they were never satisfied, the patients made the students feel inadequate as nurses.

Several studies investigated the labelling and stereotyping of patients and their effect on patient care. The findings concurred that nurses and nursing students label as difficult alcoholic patients (Harlow & Goby, 1980; Schmid & Schmid, 1973), psychiatric patients (Behymer, 1953; Belknap, 1956), patients who cry (Norris, 1957), who are obese, abuse drugs

DEBRA L. PODRASKY, R.N., M.S.N., *Delta Mu,* is a clinical nurse specialist, Yale New Haven Hospital, and Program Instructor, Medical-Surgical Nursing, Yale School of Nursing. **DOROTHY L. SEXTON,** R.N., Ed.D., *Delta Mu,* is Associate Professor and Chairperson, Medical-Surgical Nursing Program, Yale School of Nursing. The authors thank Dianne Davis, R.N., M.S.N. for her cogent comments during the preparation of this report. Correspondence to Yale School of Nursing, 855 Howard Avenue, P.O. Box 9740, New Haven, CT 06536.
Accepted for publication December 11, 1987.

or smoke cigarettes (Fernicola, 1982), and patients of lower socioeconomic status (Larson, 1977) or who have a cultural background different than that of their caregivers' (Blaylock, 1970; Hughes, Hughes & Deutscher, 1958; MacGregor, 1967; Ruiz, 1981; Schur, 1971). Once patients have been stereotyped, it is difficult for them to deviate from the label without suffering consequences (Larson, 1977; Ruiz, 1981; Taylor, 1965). Negative stereotyping carries with it a stigma that may be associated with poor-quality nursing care.

MacGregor (1967) believed that some of the "stubborn," "difficult" or "uncooperative" behaviors that patients are labelled as exhibiting may actually reflect a clash between the cultural beliefs of patients and nurses. Patients may display behavior that is culturally conditioned, and nurses, unfamiliar with that culture and its norms, may perceive it as being deviant (Hughes, Hughes, & Deutscher, 1958; Schur, 1971).

Because personality and coping mechanisms are fairly stable across time, it can be assumed that the behavior of hospitalized patients reflects their life-long beliefs, attitudes and experiences (Barry, 1984; Kahana & Bibring, 1964; Shapiro, 1965). A stressful event such as hospitalization may cause an exaggeration of coping mechanisms and personality characteristics, which in turn may lead to difficulty in the relationship that patients have with nurses (Travelbee, 1971).

Method

An exploratory survey design was used to determine what characteristics or behaviors are associated with hypothetical patients described by nurses as being "difficult," and what emotional and behavioral responses the nurses might report that they exhibit when interacting with hypothetical patient situations.

Sample

The 73 subjects included 48 registered nurses (R.N.s) and 25 licensed practical nurses (L.P.N.s) who provided direct care for at least 16 hours per week. Of the R.N. participants, 36 were prepared at the diploma level, while 7 had associate degrees and 5 held baccalaureate degrees; 21 R.N.s were currently studying for a B.S.N. degree and 9 L.P.N.s were enrolled in diploma or associate degree programs. More than half ($N = 26$) of the R.N.s had practiced nursing for less than 5 years, while more than half ($N = 14$) of the L.P.N.s had been nurses between 6 and 15 years. A majority ($N = 64$) of the subjects were between the ages of 20 and 39 years ($\bar{X} = 29.4$; $SD = 7.7$). All were female; they were primarily caucasian ($N = 69$), and most ($N = 55$) were Roman Catholic.

Instrument

The *Difficult Patient Assessment Tool* (DPAT) was developed by this investigator based on a review of the literature, personal experience and a series of conversations with nurses about problematic patients. The DPAT is composed of four subsections: Biographic Data Form, Vignette Reaction Inventory, Nurses' Response Profile, and the Unpopular Behaviors Checklist. The questionnaire was submitted to a panel of three clinical specialists and three tool construction experts to determine content validity. Interrater reliability was not determined. The instrument was then administered to a pretest sample of 20 R.N.s. Based on the results of the pilot study and recommendations of the experts, a few modifications were made to clarify the directions given to participants.

The *Vignette Reaction Inventory* contained four vignettes, which this investigator based on conversations with staff nurses about recurring patient characteristics that the nurses found to be problematic. Behaviors or key words expressed frequently were intentionally used in developing the vignettes. Each vignette described a situation in which a nurse might consider the patient to be "difficult." The four scenarios differed with respect to patient characteristics and behaviors so that a wide variety of negative reactors were included:

1. When a wealthy businessman, who continually requests one cup of coffee after another, asks for a fourth cup and there is a delay, he says to the nurse, "Hey Babe, I called ten minutes ago....What took you so long? Did you have to grind the beans or what?"
2. A middle-aged woman, who had been hospitalized for three weeks with vague complaints of lethargy, is on bedrest and calls for the bedpan during change of shift report. There is a delay and she is incontinent. The vignette implies that her incontinence was intentional.
3. An 89-year-old woman is agitated and confused. She continually manages to untie her restraints and attempts to climb out of bed.
4. A young drug abuser has minor surgery and is unable to obtain pain relief despite receiving high dose analgesics. He threatens to have street drugs brought in.

For each vignette, respondents were asked to write a short response to the questions, How do you feel about this patient? What would you do in response to this patient?

The *Nurses' Response Profile* (NRP) was used to collect data on the feelings that nurses reported having had when they cared for patients with whom there were interpersonal difficulties. The NRP contains four incomplete sentences. For example, "When I can't seem to satisfy a patient, I feel _ ." The respondents were asked to complete the items with a word or phrase that described their feelings and thoughts. The sentences were designed to convey a sense that on occasion it is normal for everyone to be frustrated and feel some burnout. The question, "Are there any other thoughts that you would like to share about caring for difficult patients?" was included at the end of this section to give respondents a chance to add further information.

The *Unpopular Behaviors Checklist* is a list of 69 words or phrases that describe patient characteristics or behaviors that could be labelled difficult, for example, demanding, uncooperative and time consuming. Items that describe similar types of problems or negative behaviors were dispersed throughout the list to avoid establishing a response set. The subjects were asked to read the list and at the same time think about the single most difficult patient whom they had ever taken care of and then circle those items that described that patient. No limit was placed on the number of items that could be circled.

Procedure

A university school of nursing's human subjects committee and designated agency persons reviewed and approved the study protocol. Return of a completed questionnaire constituted informed consent. The data were collected on medical-surgical units of a 400-bed community hospital. The nurses on all three shifts were invited to participate. Of the 199 nurses who met the criteria for inclusion in the study, 74 nurses were available and were asked to participate; 73 returned completed questionnaires.

Results

Unpopular Behaviors

Of the 69 words contained in the Unpopular Behaviors Checklist, 11 were selected by at least half of the subjects. These items were considered to represent the characteristics of patients with whom the nurses found to be the most disconcerting to work. The terms that were most often selected were "demanding" (N = 62), "complaining" (N = 46), "frustrating" (N = 45), "time consuming" (N = 43), "requesting often" (N = 42), "calling frequently (N = 41), "manipulative" (N = 40), "female" (N = 38), "impolite" (N = 38), "unreasonable" (N = 37) and "uncooperative" (N = 36).

Vignette Reaction Inventory

This tool provided data about the emotional and behavioral responses of nurses to nurse-patient scenarios in which the behavior of patients was thought to be inappropriate or difficult. Responses to each vignette were analyzed separately for both the behavioral and emotional components. After examining the data, it became clear that the responses tended to reflect a particular theme or themes. Based on these themes, categories of similar responses were established. For each of the four vignettes, behavioral responses fell into either four or five categories. In the interest of brevity the findings from only two of the vignettes are included.

Vignette 1. Responses to this vignette about the wealthy businessman were assigned to five categories (see **Table 1.**) More than half (N = 56) of the participants would respond by "orienting" him to the hospital routine. The responses included such statements as "We're busy, and coffee is a low priority" and "There are very sick patients here, and we can't always come right away." Close to one fourth (N = 25) were enraged by his attitude and/or being called "Babe." Although anger is an emotion, and behavioral responses were being analyzed, it was felt that "anger" was an appropriate term for this category because the behaviors that the respondents chose had the emotional quality of anger in them. Of the responses, 15 fell into the "independence" category—used for any response that would increase the patient's independence from the nurse, for example, showing him where the coffee machine was, or suggesting that he bring in a thermos from home.

TABLE 1. Behavioral Responses to Vignette #1 (N = 73)

	Number of Responses	Percentage of Responses
Orientor	56	52.3
Anger	25	23.4
Independence	15	14.0
Avoider	7	6.5
Parent	4	3.8
TOTAL	107*	100.0

* Adds to more than 73 because some respondents gave more than one response.

Vignette 2. The behavioral response to the vignette concerning the middle-aged woman who was incontinent fell into five categories (see **Table 2**). More than one fourth (N = 21) of the responses centered on making the woman more independent by "leaving the bedpan within reach" or "obtaining a commode." Of the responses, 11 focused on "explaining" why there was a delay, while 10 attempted to "diagnose" organic causes for the incontinence and 8 "sympathized" with her situation. However, 29 subjects responded to her incontinence by wanting to punish her.

TABLE 2. Behavioral Responses to Vignette #2 (N = 73)

	N	%
Punisher	29	36.7
Independence	21	26.6
Explainer	11	13.9
Diagnoser	10	12.7
Sympathizer	8	10.0
TOTAL	79*	100.00

*Adds to more than 73 because some respondents gave more than one response.

Emotional Responses

The emotional responses to each of the vignettes were analyzed in a manner similar to that for the behavioral responses. The categories established for the emotional responses contained the entire spectrum of degree or intensity of that emotion. For instance, the category "Anger" included extreme responses such as "enraged" and "out of control" as well as "irritated" or "annoyed." If participants did not explicitly state an emotion, the response was assigned to the heading "No Emotion Stated."

The emotional responses to vignette 1 included primarily anger (N = 47), frustration (N = 15), and feelings such as upset, hurt, and offended (N = 11). In addition, there were subjects who did not state how they felt (N = 14). The incontinent patient's responses were similar in that 44 subjects felt anger, 17 felt frustrated and 7 were either upset, guilty or sorry. When the responses to each vignette were rank ordered, it was noted that for three of the four vignettes, the top three emotional responses were "Anger," "Frustration," and "No Emotion Stated."

The Nurses' Response Profile

Data obtained from the NRP were analyzed with methods similar to that of the vignettes. For the Nurses' Response Profile the nurses were asked to complete the following five sentences

1. When I can't seem to satisfy a patient, I feel .....
2. There are times I feel that I can't face another day of certain patients, especially when they .....
3. Sometimes I feel .....toward patients who continually try my patience.
4. When I get frustrated about a patient situation, I .....
5. When a "demanding patient" keeps putting his/her light on, I find myself .....

Again, there were recurring feelings of anger and frustration. To the first incomplete sentence, a majority (N = 54) of the participants reported that they felt frustration, 14 participants internalized the inability to satisfy the patient by feeling inadequate, incompetent, and helpless, and 6 subjects reported that they felt angry. For the third incomplete sentence, a majority (N = 58) of the subjects felt anger. Other responses included "Hatred" (N = 6) and "Frustration" (N = 2), while 10 expressed such feelings as weepy, worn out, and impatient. Data from items two, four and five are not reported here because they yielded both feelings and behaviors.

Open-Ended Question

Responses to the item "Are there any other thoughts that you would like to share about caring for difficult patients?"

could be grouped into two categories. The areas of concern were (a) why caring for difficult patients can be more frustrating at some times than at other times and (b) what nurses do or would like to do to make it easier to interact with these patients. The nurses reported that their level of frustration and anger with difficult patients was dependent on such factors as their mood, the number of hours they work per week, the degree of busyness of the unit, the number of years they had spent in nursing, their past experiences with difficult patients and to what extent the patients were actually unable to control their behavior. The second area of thoughts expressed by subjects included "Nurses need rights too," "The same nurse shouldn't always work with the same patient, it leads to burnout quicker" and "Sometimes it's so frustrating I don't want to be a nurse anymore."

Although the information obtained from this open-ended question did not provide new data regarding difficult patients, it served to clarify further the recurring themes of nurse frustration, burnout, and situational variables that affect the degree of response that nurses have when interacting with difficult patients.

Additional Findings

A reanalysis of the data revealed some striking responses. These 34 responses were found throughout the data but were especially elicited through the vignettes ($N = 19$). Some of the participants reported that they would react to situations described in the hypothetical vignettes with statements such as "You're an asshole and deserve to be in pain, " "I think you're gross and disgusting," "I'd tell him, I'm not your Babe you rich bitch, get off my back and hire a private duty nurse if you're so rich" and "I'd tell him to go to hell." Another group of these unexpected responses described actions that the nurses reported they would perform or would like to perform, including: "I have to keep myself from hauling off and wacking her one," "I would restrain her just a little bit too tight," "I'd make her stay in the wet bed for a long while," "The only way to get her out of it [the behavior] would be regular beatings" and "I feel like throwing coffee in his face." Other examples of these types of responses included "I think he's a pompous, selfish jerk," "I hate this person" and "I feel like I could kill."

The biographical and educational characteristics of the 19 subjects who responded in this fashion were then analyzed in an attempt to understand these responses. When the characteristics of these subjects were compared with the others in the sample, they were similar with two exceptions. All 19 subjects reported that they were Catholics and 15 of them were married. These data were unexpected, and this investigator was not prepared to interpret them.

Discussion

This study was conceived as an effort to understand poor nurse-patient relationships where the source of the difficulty is thought to originate primarily with the patient. Patients to whom nurses react negatively can be described as demanding, complaining, frustrating, time consuming, requesting often, frequently calling, manipulative, female, impolite, unreasonable and uncooperative. Similar characteristics have been reported by others (Ritvo, 1963; Ujhely, 1967).

Blaylock (1970) found the most commonly reported undesirable traits of patients to be demanding, stubborn, does not listen, self-centered, on the call light, complaining and rude. The present investigation found that the label "difficult patient" is more likely to be used when the patient has characteristics or behaviors that are modifiable rather than those that are essentially "not one's fault." Characteristics over which the patient has no power, for example, being surgical, medical, chronic, acute, infectious, or mentally retarded, did not rate highly as factors in determining who was considered a difficult patient. This was interpreted to indicate that there is less tolerance for those negative traits that are learned and not inborn because the person is expected to have some degree of control over them. Characteristics that are not changeable were viewed as being something imposed on the patient rather than a chosen behavior pattern; thus they were more easily tolerated.

Schmid and Schmid (1973), comparing nursing students' attitudes toward and acceptance of alcoholic and physically disabled patients, also found that the potentially modifiable negative characteristics were less tolerated than were the nonmodifiable traits. In the present investigation there was one exception to this. Although a person has no control over their sex at birth, the trait of "being female" was reported by more than half ($N = 38$) of the participants as being a characteristic of a difficult patient. Males rated much more favorably: only about one third ($N = 26$) of the sample indicated that it was the trait of a difficult patient. The reason for this difference is unclear, although some authors report female patients to be generally more time consuming and more likely to be uninhibited in their emotional reactions to hospitalization (O'Connor, 1958; Kuhn, 1980).

The typical scenario proceeds like this: a person who has characteristics that nurses identify as difficult is hospitalized. This causes the patient stress, which is dealt with by using past coping mechanisms that may or may not be helpful. Nurses view these behaviors as "difficult." Their coping abilities may be influenced negatively by outside factors such as their past experiences, how long it has been since their last day off, whether or not the floor was busy at the time, and many others. When patients exhibit a behavior that nurses consider to be "difficult," these patients are quickly labelled "difficult." The nurses' frustration and anger level rise with each interaction. They therefore either try to ignore the patients or they fight with them, both of which make them work all the harder, using their past coping mechanisms. The cycle continues, leaving nurses and patients unsatisfied, frustrated and tired.

Frustration and anger are the two most common emotions that the nurses felt when interacting with difficult patients. It is understandable that nurses might be frustrated and angry when one considers that the negative behaviors exhibited by difficult patients are extremely repetitive and that patients' coping mechanisms may be at a lower, less sophisticated level of behavior (Lazarus & Folkman, 1984; Mayou, 1984; Moos, 1977). The behaviors in most instances may simply reflect their personality; in other instances, they are coping mechanisms for patients in stressful environments such as a hospital. These negative behaviors are therefore present in some portion of the hospitalized population at any given time.

The behavioral data obtained from the vignettes contained underlying themes. The nurses most often reacted behaviorally with a classical fight/flight response rather than seeking to determine the reason for the negative behavior or attempting a therapeutic action. At times the fight response was mani-

fested as potentially hostile acts or impulses toward patients or by taking out anger with a third party or object. For example, some nurses said that they would take out their feelings of anger on family members or the dog. The flight response was exhibited by ignoring or avoiding the patient. Nurses' use of avoidance and distancing in response to difficult patients has been identified by several authors (Flaskerud, Halloran, Janken, Lund & Zetterlund, 1979; Janken, 1974; Williams, 1974). Janken believes that avoidance is a coping mechanism that nurses use when they experience crisis and lack situational support.

When Fischelis (1961) compared the labels that nurses attach to patient behavior and the effect this has on nursing activities, she found that nurses who labelled a problem patient's behavior did not explore effectively with the patient the meaning of the behavior. Because the meaning of the behavior was not explored effectively, the nurse intervened in ways that did not benefit the patient. Janken (1974) concurred that, once nurses label patients, they are no longer able to process patient data because they see only one aspect of the total person.

There are multiple possible reasons why the nurses in this study reacted nontherapeutically to the behavior of hypothetical difficult patients. First, they may have lacked the necessary training and skill to deal with these behaviors. Only six subjects held a bachelor's degree, and of these only five held that degree in nursing. The remaining subjects were prepared as LPNs ($N = 24$), and diploma R.N.s ($N = 36$) or associate degree R.N.s ($N = 7$). Also, regardless of the type of educational preparation, the nurses may not have had formal training related to coping with difficult patients. The lack of skills and training has been cited as an intervening variable in poor nurse-patient relationships (Harlow & Goby, 1980; Highley & Norris, 1957; Ritvo, 1963).

Secondly, it is thought that the emotional tone of a unit often has a strong influence on nursing styles and the way in which nurses interact with patients. Negative attitudes and feelings often serve as guiding forces that perpetuate stereotypes (Fernicola, 1982), labelling (Behymer, 1953) or general avoidance behaviors (Belknap, 1956; Highley & Norris, 1957). When a nurse does not follow such mores of the unit in which she works, she may find herself ostracized from her group of coworkers.

Another possible explanation of these nontherapeutic responses may relate to the subjects' conscious or unconscious use of the research questionnaire as a vehicle in which to ventilate their feelings. Caring for difficult patients can be exasperating and frustrating for caregivers. Because the questions focused on feelings and reactions to difficult patients, the DPAT may have prompted nurses to release some of their pent-up frustrations in what they believed to be a safe environment. Actually, using the questionnaire as a "relief valve" rather than targeting the patient and family members or internalizing it to oneself is a safer, healthier response. Unfortunately, it may have skewed the results, making the subjects' behavioral responses appear to be less therapeutic and more abusive in nature than are their real-life interactions with patients.

The underlying purpose of this study was to identify patient characteristics or behaviors that nurses labelled "difficult" and to discover how nurses react emotionally and behaviorally to hypothetical situations with difficult patients. Such information could be useful in breaking a frustrating cycle of poor nurse-patient relationships and could contribute to a better understanding of these patients, which would in turn help nurses to develop appropriate coping patterns for interacting with them. Information derived from the study could be used as a foundation for designing educational programs and for pursuing further research. Areas that may be useful to explore include identifying how nurses respond to actual interactions with difficult patients, investigating the dynamics involved when nurses respond to patients in unusually negative ways and measuring the outcome of interventions designed to improve nurse-patient relationships.

References

Barry, P. D. (1984). **Psychosocial nursing assessment and intervention.** New York: J.B. Lippincott.

Behymer, A. F. (1953). Interaction patterns and attitudes of affiliate students in a psychiatric hospital. **Nursing Outlook, 1,** 205-207.

Belknap, I. (1956). **Human problems of a state mental hospital.** New York: McGraw Hill.

Baylock, J. (1970). **Characteristics of nurses and of medical-surgical patients to whom they react positively and negatively.** Unpublished doctoral dissertation, Teachers College, Columbia University, New York.

Dichter, E. (1954). Study of the hospital patient relationship. **Modern Hospital, 83**(3), 51-54.

Diers, D. K. (1964). **The nurse orientation system: A method for analyzing nurse-patient interactions.** Unpublished master's thesis, Yale University School of Nursing, New Haven, CT.

Elms, R., & Diers, D. (1963). The patient comes to the hospital. **Nursing Forum, 2**(3), 88-89.

Fernicola, J. (1982). **Stigmatization by nurses of patients with self-inflicted illnesses.** Unpublished master's thesis, Yale University School of Nursing, New Haven, CT.

Fischelis, M. C. (1961). **An exploratory study of labels nurses attach to patient behavior and their effect on nursing activities.** Unpublished master's thesis, Yale University School of Nursing, New Haven, CT.

Flaskerud, J. H., Halloran, E. J., Janken, J., Lund, M. & Zetterlund, J. (1979). Avoidance and distancing: A descriptive view of nursing. **Nursing Forum, 18**(2), 158-174.

Harlow, P., & Goby, M. (1980). Changing nursing students' attitudes toward alcoholic patients: Examining effects of a clinical practicum. **Nursing Research, 29**(1), 59-60.

Highley, B. L., & Norris, C. M. (1957). When a student dislikes a patient. **American Journal of Nursing, 57**(9), 1963-1166.

Hover, J., & Juelsgaard, N. (1978). The sick role reconceptualized. **Nursing Forum, 17**(4), 407-415.

Hughes, E., Hughes, H., & Deutscher, I. (1958). **Twenty thousand nurses tell their story.** Philadelphia: J. B. Lippincott.

Jaco, E. G. (1958). **Patients, physicians and illness.** Glencoe, IL: The Free Press.

Janken, J. K. (1974). The Nurse in crisis. **Nursing Clinics of North America, 9**(1), 17-26.

Kahana, R., & Bibring, G. (1964). Personality types in medical management. In N. Zinberg (Ed.), **Psychiatry and medical practice in a general hospital** (pp. 108-123). New York: International Universities Press.

Keller, N. S. (1971). Compliance, previous access and provision of services by registered nurses. **Journal of Health and Social Behavior, 12**(4), 321-330.

Kuhn, B. G. (1980). Prediction of nursing requirements from patient characteristics. **International Journal of Nursing Studies, 17**(1), 5-15.

Larson, P. A. (1977). Nurse perceptions of patient characteristics. **Nursing Research, 26**(6), 416-421.

Lazarus, R., & Folkman, S. (1984). **Stress, appraisal, and coping.** New York: Springer.

MacGregor, F. C. (1967). Uncooperative patients: Some cultural interpretations. **American Journal of Nursing, 67**(1), 88-91.

Maxson, K. (1974). Assuming the patient role. **Perspectives in Psychiatric Care, 12**(3), 119-122.

Mayou, R. (1984). Sick role, illness behaviors and coping. **British Journal of Psychiatry, 3**(10), 320-322.

McNellis, N. P. (1979). Are there true problem patients? **American Journal of Nursing, 79**(10), 1742-1744.

Moos, R. H. (1977). **Coping with physical illness.** New York: Plenum Medical Book Co.

Norris, C. M. (1957). The nurse and the crying patient. **American Journal of Nursing, 57**(3), 323-327.

O'Connor, E. T. (1958). **A comparative study of the differences in the number and**

nature of requests made by patients on a private ward and by patients on a semi-private ward in a general hospital. Unpublished Master's thesis, Yale University School of Nursing, New Haven, CT.

Orlando, I. D. (1961). **The dynamic nurse-patient relationship.** New York: G. P. Putnam's Sons.

Peterson, D. (1967). Developing the difficult patient. **American Journal of Nursing, 67**(3), 522-525.

Ritvo, M. M. (1963). Who are "good" and "bad" patients? **Modern Hospital, 100**(6), 79-81.

Robinson, L. (1976). **Psychological aspects of the care of hospitalized patients.** Philadelphia: F. A. Davis.

Ruiz, M. J. (1981). Open-closed mindedness, intolerance of ambiguity and nursing faculty attitudes toward culturally different patients. **Nursing Research, 30**(3), 177-181.

Sarosi, G. M. (1968). A critical theory: The nurse as a fully human person. **Nursing Forum, 7**(4), 349-363.

Schmid, N., & Schmid, D. (1973). Nursing students' attitudes toward alcoholics. **Nursing Research, 22**(3), 246-248.

Schur, E. (1971). **Labeling deviant behavior: Its sociological implications.** New York: Harper & Row.

Schwartz, D. (1958). Uncooperative patients? **American Journal of Nursing, 58**(1), 75-77.

Selye, H. (1976). **The stress of life** (2nd Ed.). New York: McGraw-Hill.

Shapiro, D. (1965). **Neurotic styles.** New York: Basic Books.

Strauss, A., & Glaser, R. (1964). **Expecting patients to die: Temporal aspects of status passage.** San Francisco: University of California Medical Center.

Suchman, E. (1966). Health orientation and medical care. **American Journal of Public Health, 55,** 97-105.

Taylor, C. D. (1962). Sociological sheep shearing. **Nursing Forum, 1**(2), 78-89.

Taylor, C. D. (1965). The hospital patient's social dilemma. **American Journal of Nursing, 65**(10), 96-99.

Travelbee, J. (1971). **Interpersonal aspects of nursing.** Philadelphia: F. A. Davis.

Ujhely, G. (1967). **The nurse and her "problem" patients.** New York: Springer.

Ujhely, G. B. (1968). **Determinants of the nurse-patient relationship.** New York: Springer.

Vincent, P. (1975). The sick role in patient care. **American Journal of Nursing, 75**(7), 1172-1173.

Williams, F. (1974). The Crisis of hospitalization. **Nursing Clinics of North America, 9**(1), 37-45.