

# Behavior Contracts in Psychiatric Practice and Everyday Situations: A Psychological and Psychiatric Viewpoint

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**Abstract:** In recent years, “difficult” patients have gained attention, and behavior contracts have been introduced into clinical practice. This is because some patients behave inappropriately toward healthcare providers, and behavior contracts require patients to refrain from such behavior. However, it has been highlighted that behavior contracts have ethical problems. We present an ethical analysis of behavior contracts from the viewpoint of psychiatric practice and patient psychology. We analyze why patients become “difficult” for medical practitioners and explain why consideration must be given to the psychological aspects of the patient and the burden of mental illness. Behavior contracts are inappropriate because they do not consider individual patients’ psychological or psychiatric conditions and are applied uniformly. Moreover, the behavioral model that behavior contracts assume is not justified by today’s psychiatry. Furthermore, in this article, we show how behavior contracts promote the stigmatization of mental illness. For these reasons, we argue that the use of behavior contracts in clinical practice is not ethically justified. However, we add that physical violence against healthcare providers should not be tolerated under any circumstances.

**Keywords:** behavior contracts; difficult patients; behavior analysis; stigmatization; medical ethics



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## 1. Introduction

Burnout is a significant problem in clinical practice, not only because of the psychological burden it imposes on medical staff but also because it is detrimental to the quality of patient care. Workplace stress is one of the major causes of burnout, and verbal abuse and inappropriate behavior from “difficult” patients toward healthcare providers also contribute to the burnout of healthcare providers. For this reason, some medical institutions have introduced “behavior contracts”, which require patients to behave appropriately. Some of these behavior contracts call for discharge or discontinuation of medical care when the patient behaves inappropriately. In a recent article, Fiester and Yuan [1] addressed behavior contracts in clinical medical practice and highlighted their ethical issues, concluding that behavior contracts have many challenges and should not be carelessly used in clinical practice. They identified the following six issues with behavior contracts. First, behavior contracts lumped together all stated undesirable behaviors, drawing the same ultimate Draconian penalty. Second, they demand propriety and excellent manners as conditions for either receiving medical care or accompanying someone who is receiving medical care. Third, they view the behavior as a problem and not a symptom. Fourth, they turn persuasion into control and coercion. Fifth, these standards cannot be applied equally or universally. Sixth, they radically alter the role and scope of the clinical ethics consultation practice. The conclusions of this ethical analysis are valid. Fiester and Yuan [1] rightly point out the importance of the patient’s family and the critical issue of the difficulty of reconciling the position of the healthcare ethics committee to resolve conflicts and behavior contracts. Behavior contracts are a legal formality and not a problem that

can be solved solely by frontline medical staff. However, there is little explanation for why the patients who are asked to sign behavior contracts are perceived as “difficult” by medical practitioners. Some studies define difficult patients as those who raise negative feelings within the clinician [2]. However, this definition was given from the perspective of the medical staff [3], not from the etiology of difficulty. Fiester and Yuan [1] did not fully analyze the root cause of the problem in the field. In addition, even if behavior contracts were first applied in the psychiatric field, psychiatric-related cases are still a problem today, although they were not analyzed in the previously mentioned article. We believe that it is also necessary to analyze the issue of violence in the medical field, which is painful for both medical staff and patients and difficult to tackle, an aspect that Fiester and Yuan [1] refrained from discussing.

For these reasons, we expand on the arguments of Fiester and Yuan [1] and further highlight the psychological aspects of patients from the perspective of psychiatric practice. In addition to the inappropriateness of their use in general clinical practice, we analyzed the use of behavior contracts in areas with psychological and psychiatric burdens, such as psychiatric care and psychiatric liaison consultation areas for psychological distress associated with intractable diseases. However, we would like to add a reservation stating that strong interventions should be implemented in response to physical violence in the medical setting.

## 2. Patient Psychology and Vulnerability Underlying “Difficulty”

Regarding the characteristics of behavior contracts that require patients to behave appropriately toward healthcare providers within a healthcare institution, Fiester and Yuan [1] stated the following:

*This one-sided, provider-directed nature of behavior contracts described by Mann is what led patient-centered care advocate, Timothy Quill, to try to reconceive behavior contracts as a kind of “partnership” that involves negotiation, mutual gain, and bilateral power (Quill 1983). But the Quill approach to behavior contracts, which tried to “challenge authoritarian modes of patient care” (Quill 1983, 228), has rarely been adopted by those who use behavior contracts in the clinical setting.*

The reason Quill’s argument was not accepted in behavior contracts in the clinical setting may be that it is inevitable in an individualistic contractual society. However, Quill’s argument for patient-centered care is broadly accepted in today’s American society. It is natural for contracts to be important in the United States, a contractual society. However, we have some concerns about the overemphasis on “contract” in clinical care.

Clinical medical care settings are completely different from the spaces in which healthy people live. Unlike a situation in which a typical contract is concluded, many characters appear in the medical context with the background of a complex balance of power. There are patients, families, and healthcare professionals. Among them, patients and families with illnesses are the most vulnerable. This underlying context is the reason difficulty is felt only by the medical staff. However, while healthcare professionals can treat non-difficult patients with compassion, when they feel difficulty, they are unable to understand the psychology, personality, and diverse cultural backgrounds of “difficult” patients. “Difficult” patients appear among vulnerable patients in these situations. Furthermore, incurable patients may experience extreme mental instability. In a psychiatric ward, both patients and their families may be overwhelmed by an uncertain future.

The question is, when using behavior contracts, do healthcare professionals really make an effort to understand why patients and families are difficult? Do they fully understand the psychology of the patients and their families? If the answer is no to either question, the relationship of trust between patients/families and healthcare providers becomes increasingly challenging.

In his classic article on “difficult” patients, Groves [4] described four types of such patients in outpatient settings and analyzed the psychological processes that lead them to behave in these “difficult” ways. The behavior contract is extremely naive, as it simply asks

patients who are perceived as “difficult” by the medical staff to uniformly sign the same form of confirmation without considering these classic typologies. For example, Groves [4] categorized “difficult” patients as “clingers”, “demanders”, “help-rejecters”, and “self-destructive deniers.” However, if behavior contracts confuse “self-destructive deniers”, who “find their main pleasure in furiously defeating the physician’s attempts to preserve their lives”, and other categories, the patient would be, perhaps willingly, discharged according to the terms of the behavior contracts and would simply repeat the same behavior in other medical facilities, and those discharges falsely deepen their convictions. Thus, uniformly adapted behavior contracts may encourage problematic behavior. However, one size does not fit all. Especially in psychiatry ethics, respect for people is vital. This “regard[s] the ill individual fully, genuinely, intrinsically” and pays attention to “the ill individual’s life history; personal, cultural, and spiritual values; preferences; and dignity” [5], and behavior contracts neglect this ethical importance of persons. However, the problem with Groves’ typology is that it assumes that the primary care physician is the sole person in charge of handling the case. Now that the importance of collaboration among medical professionals is understood, it is appropriate to deal with such patients in collaboration with community health workers, such as public health nurses. Collaborative care models that use telepsychiatry techniques would also be helpful. The same is true for inpatient settings. Patients who are perceived as “difficult” by healthcare providers are likely to face difficulties. These difficulties may be pain, lack of prognosis, insecurity due to unstable employment, or even poverty and unstable housing due to unreliable income. If these are social difficulties, cooperation with social workers is necessary. If it is a childcare issue, it may be necessary to connect with the local child consultation center. Asking the patient not to behave in such a way, without analyzing the psychological and background factors of the difficulty, may conceal the difficulty, increase the patient’s suffering, and violate the principle of non-maleficence.

It is common for patients with addiction and other psychiatric disorders to become easily agitated because of fear and anxiety during the exacerbation of psychiatric symptoms. However, during these times of aggravation, patients require the most care. It is known that “difficult” patients are more likely to suffer from psychiatric disorders [6]. Terminating the therapeutic relationship based on a contract at that moment is tantamount to declaring that “patients who are unwell are not eligible for treatment”, which, simply put, violates the principle of beneficence. Even if not for mental illness, Kübler-Ross adequately captured “anger” in a five-stage model within the normal clinical course [7]. If the behavior contract abandons this “anger” and regards it as nonsense, it fails to recognize the classic and widely known findings of clinical psychiatry. In psychiatry, the terms “negative feelings” [8] and “negative attitudes” [9] have been used to describe the anger and frustration that medical professionals feel toward their patients as normal psychology. In addition, psychiatry has also isolated the negative effects that clients have on their therapists as “negative transference” [10], which is considered key to treatment. It is unfair if the patient, the party experiencing the greater suffering, is not allowed to experience “anger”, “agitation”, or “grief” despite these psychological and psychiatric findings. Emotional expression promotes dialogue and acceptance of the disease. Compassion begins with an understanding of the emotions of both the healthcare provider and patient, for each other. The equality of emotions should be accepted as necessary.

### 3. Effective and Acceptable Intervention from a Behavioral Health Perspective

Fiester and Yuan [1] coincidentally cited Mann’s behavioral treatment program [11] as one of the origins of the behavior contracts. In line with the growing knowledge in behavioral science, behavioral interventions occupy an important area of modern psychiatry. This includes the field of addictions, such as alcoholism and drug abuse, and non-substance dependence, such as gambling and Internet addiction, in the more modern sense [12], as well as judicial psychiatry, such as sexual offenses, and child psychiatry, such as challenges in the educational setting. These areas require more behavioral in-

terventions than pharmacotherapy, and programs are currently being built in addiction centers, self-help organizations, and judicial and educational departments based on various psychotherapeutic approaches. Although various theoretical improvements have been made for flourishing these programs, Mann's approach is problematic from the perspective of behavioral psychiatric practices. Mann's program is based on the premise of "punishing or aversive consequences" and the punishment of patients, which leads to the following two problems.

First, the use of punishment to change behavior is unfavorable from a psychotherapeutic perspective. In line with the concept of motivational interviewing, a form of addiction psychotherapy that respects the patient's autonomy while simultaneously changing behavior and similar treatment methods, punishment is an external regulation that most disrespects patients' autonomy [13]. Although motivational interviewing is based on behavior analysis [14], the use of punishment for behavioral change is currently discouraged, especially because it is known to undermine patient trust. In the field of addiction treatment, we encountered cases in which patients who failed to adhere to such behavior contracts were refused visits to various hospitals and did not receive appropriate medical care. As far as psychiatric ethics require particular attention to the behavior and motivations of patients [5], not doing so is questionable from the perspective of the duty of care.

Second, the punishment-based response is problematic as it causes mental illness, in which behavior control is difficult, to appear as a moral sin. As Fiester and Yuan appropriately noted in the case of addiction, which is defined in the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases as a behavior control disorder [15], if the behavior contract penalty is given in response to a failure to control behavior, which is a preponderant challenge in some mental disorders, then mental illness would be treated as a moral sin.

Therapists and peer supporters often encounter baffling patient behaviors in clinical situations. However, Pickard's concept of "responsibility without blame" suggests that it is possible to continue treatment by facilitating the patient's agency with compassion and empathy, without condemning the patient as completely responsible or assuming that the patient is incapable of responsibility owing to mental illness [16]. Thus, if a behavior contract has an aspect of punishment, it is highly inappropriate, at least when it pertains to mental illness.

#### **4. Resolute Response to Violence and Sexual Harassment**

Although we believe that behavior contracts should not be used in medical practice from an ethical standpoint, we would like to emphasize that physical violence and sexual harassment in medical practice are unacceptable. Physical violence against medical personnel is a global problem [17]. Although Fiester and Yuan [1] do not go into detail, perhaps thinking that they are facing a line-drawing problem, it is common in medical practice to request police intervention when violence or threats of violence escalate, even in the field of psychiatry, which conscientiously deals with the delicate psychological state and psychiatric symptoms of patients. Physical and sexual harassment by medical personnel is another major problem. In addition, damage to hospital property may also be subject to criminal law enforcement or reimbursement. In the event of such a legal problem, it is important to take a firm stand and consider reporting or consulting with the police to protect the human rights of frontline medical staff that are legally guaranteed. It should be noted that even if police intervention occurs, it does not always result in the interruption of treatment, and it is often the case that hospitalization continues after such an incident, which is the difference between police reporting, judicial intervention, and behavior contracts. It should be reaffirmed that medical personnel, as citizens and not privileged individuals, also have basic human rights.

## 5. Conclusions

To understand why patients are compelled to behave in difficult ways, it is necessary to understand the psychology of individual patients and the burden of their mental illness. Behavior contracts can destabilize the physician–patient relationship because they disregard these factors, apply inappropriate behavioral models, and cause stigmatization. Ethically, the use of behavior contracts is unacceptable. To reduce difficulties in the healthcare setting, healthcare providers need to cooperate with various professionals to alleviate the difficulties that patients experience, from the perspective of patient-centered care. In particular, healthcare professionals can consult with healthcare ethics committees and collaborate with social workers to respond appropriately in ways that take into account the cultural and social determinants of health. Such cooperative intervention would make it less likely for patients being perceived as “difficult.” However, even with such interventions, “difficult” patients might emerge and escalate their behavior to physical or sexual harassment. In these cases, it is necessary to take decisive action, including police intervention, to protect the human rights of the medical staff.

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