Dealing With Difficult Patients in Your Pain Practice

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Pain patients can be difficult. They can provoke negative feelings of frustration and anger among clinicians and damage the doctor-patient relationship. This article helps practitioners to identify those pain patients who would be prone to difficult behavior and sheds light on some of the reasons behind the behavior that give rise to difficult feelings. Issues of comorbid psychopathology, hostility, suicidality, aberrant drug behavior, and chronic noncompliance are discussed. Specific recommendations are also given of the best ways to manage patients with difficult behavior. *Reg Anesth Pain Med 2005;30:184-192.*

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An estimated 10% to 60% of patients treated in health-care settings exhibit "difficult behavior."[1-5] Pain patients can be especially difficult because they have a tendency to be angry, argumentative, mistrustful, anxious, and depressed.[6,7] Depression and anxiety disorders are 2 to 3 times more prevalent among chronic-pain patients than in the general population,[8,9] and pain patients frequently present with comorbid emotional liabilities such as rage, inflexibility, and entitled behavior. Difficult pain patients may strongly disagree with the physician's assessment or treatment and can have idiosyncratic reactions to neural block procedures, such as a severe provocation of pain in the absence of any procedural complication. They can also display destructive behaviors, such as threats of suicide, self-mutilation, extreme noncompliance with treatment, and opioid misuse. Most pain specialists have little training in psychiatric assessment and treatment, and many clinicians avoid pain medicine practice altogether because of the emotional challenge of working with demanding and draining patients. Although dealing with difficult patients is always a challenge, a clinician need not be a mental health expert to provide effective care to such patients in a pain practice. The aim of this article is to help pain clinicians understand why patients can be difficult, to identify those patients who are prone to such problems, and to discuss possible interventions to help both the patient and the health-care professional cope successfully.

Who Are Difficult Patients?

Typically, difficult patients are those who raise negative feelings within the clinician, such as frustration, anxiety, guilt, and dislike. They often fail to respond to nerve blocks, medications, or physical therapy, and they may be noncompliant with treatment, harbor objections to their physicians' approaches to their care, or be resistant to forming an effective alliance with their medical providers. Individuals with chronic pain may be more likely to be difficult because of the many psychosocial stressors that arise from having chronic pain and the impact of these comorbid stressors upon mood, adjustment, coping, self-esteem, and personality. Chronic-pain patients often have feelings of worthlessness, loneliness, and fear of abandonment, and they may become socially isolated and develop expectations of harm and disappointment. Some of these patients have histories of childhood physical and sexual abuse or underlying personality disorders, which places them at risk for becoming increasingly anxious, dependent, obsessive, or paranoid. These psychological symptoms, in turn, may lead to a preoccupation with physical symptoms,

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which tends to amplify the perception of pain. In summary, difficult patients in any pain practice often have suffered tremendously, feel tormented by their pain, and typically lack skills to cope with their distress.

In a study of more than 500 adults who presented to a primary-care clinic, Jackson and Kroenke[5] found that treating physicians rated more than 15% of their patients as difficult. These patients tended to have a depression or anxiety disorder, poor functional status, unmet expectations, reduced satisfaction, and a greater use of health-care services. The study also showed that physicians who were less empathic were more likely to perceive encounters as difficult. In a subsequent study, Jackson and Kroenke[10] found that unmet expectations were common among patients perceived as difficult by clinicians. The authors concluded that diagnostic and prognostic information are valued by patients and implied that patient education may help to decrease difficult behavior.

For health-care providers, treating chronic-pain patients can lead to feelings of anger, of inadequacy, and of being manipulated, which, in turn, can even lead to actively disliking certain patients. Because physicians are under increasing time pressures, pain patients who exhibit vague symptoms and who are unresponsive to many different interventions for pain can be particularly frustrating, especially when the burden of providing treatment is shouldered by a lone individual rather than by an interdisciplinary team.

Not all patients with difficult behavior exhibit significant psychopathology, such as major depression, anxiety, or a personality disorder. Patients who are otherwise "normal" can also be perceived as difficult; for example, when they arrive at a pain center for treatment with unrealistic expectations about what should happen. They may have had problems in previous health-care settings in which they were accused of exaggerating their pain. Lack of sleep, extreme fatigue, poor eating habits, and long travel to their appointments can also contribute to volatile and unstable behavior. They may feel that their physicians are dismissive or skeptical of their pain, rather than understanding and sympathetic. Even comparatively well-adjusted patients can have the idea that their pain physician should be able to eliminate all of their pain and that failure to do so is tantamount to withholding treatment. This perception becomes a critical issue when medication regimens involving opioids are concerned. Patients may worry about being prescribed adequate amounts of medication or experiencing withdrawal symptoms if they are to be tapered off opioids.

What Is the Effect of Difficult Patients on Clinic Practice and Staff?

Difficult patients drain clinic time and financial resources. They tax staff relationships and deplete emotional energy. Staff members report feeling "beat up" after interacting with these patients, which leads to low morale and high staff turnover. Difficult patients can keep staff members on edge for fear of an outburst, and staff members report feeling helpless and vengeful in the wake of such encounters. Some difficult patients are prone to making threats of legal reprisals because of perceived medical negligence or improper treatment.[11] Clinicians with limited training and experience in dealing with difficult patients may be prone to hostile retaliation, which tends to escalate problems.

How Can I Identify and Categorize Difficult Patients?

Hahn et al.[2] developed a 30-item Difficult Doctor-Patient Relationship Questionnaire (DDPRQ), which classified 10.3% to 20.6% of patient encounters as "difficult." The authors reported that difficult patients in primary-care settings tend to have psychosomatic symptoms and abrasive personality styles and often meet diagnostic criteria for a personality disorder.[3] In a study involving more than 600 patients, physicians rated 15% of patients as difficult, and of these patients, 67% met criteria for a psychiatric disorder, such as somatoform disorder, panic disorder, dysthymia, generalized anxiety, major depression, and alcohol dependence.[4]

Difficult patients have very different coping styles. James Groves[12] was one of the first clinicians to describe types of difficult patients. He classified these patients as falling into 1 of 4 groups: (1) dependent clingers, (2) entitled demanders,(3) manipulative help-rejecters, and (4) self-destructive deniers. He recommended treatment strategies for each of these patient types as shown in Table 1.

How Do I Address the Patient's Expectation to Be Fixed?

Some patients may expect a pain specialist to eliminate their pain completely or to "fix" them, and the inevitable disappointment and necessity of revising expectations may be turned against the physician. Some pain physicians may also believe themselves capable of providing complete relief from chronic pain. Anyone's unrealistic expectations can give rise to difficult doctor-patient relationships.

Difficult pain patients often see themselves as "broken" by pain, and, although treatments may lead to partial relief of pain and some improvement in function, pain and disability often persist. Some