Treating the Difficult Pain Patient Population

Mark S. Wallace, M.D.
Professor of Clinical Anesthesiology
University of California, San Diego
Why are Pain Patients Difficult?

• 10%-60% of patients treated in the allopathic healthcare system exhibit “difficult behaviors”.
• Incidence of difficult patients higher than in other medical specialties
• Depression and anxiety 2-3X more prevalent than general population
• Comorbid emotional disturbances
• More likely to have idiosyncratic increase in pain with interventional therapies
• Physicians have inadequate training in psychiatric assessment and treatment
## Effects of Chronic Pain on the Patient

<table>
<thead>
<tr>
<th>Physical Functioning</th>
<th>Psychological Morbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ability to perform activities of daily living</td>
<td>• Depression</td>
</tr>
<tr>
<td>• Sleep disturbances</td>
<td>• Anxiety</td>
</tr>
<tr>
<td></td>
<td>• Anger</td>
</tr>
<tr>
<td></td>
<td>• Loss of self-esteem</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Consequences</th>
<th>Societal Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Relationships with family and friends</td>
<td>• Healthcare costs</td>
</tr>
<tr>
<td>• Intimacy/sexual activity</td>
<td>• Disability</td>
</tr>
<tr>
<td>• Social isolation</td>
<td>• Lost workdays</td>
</tr>
</tbody>
</table>

The Pain Experience: A Biopsychosocial Perspective
Pain Patients are Complicated

- Genetics
- Depression & Anxiety
- Social Disability
- Physical Injury
- Cognitive Dysfunction

Cultural Background

Environmental Stressors

Functional Disability

Patient “A”
Pain 8/10

Patient “B”
Pain 8/10

Patient Expectations During a Clinical Encounter

• Feel Welcome
• Feel Important and Informed
• Believe their Perspective was understood
• Feel Secure that their needs will be met

Who are the Difficult Patients?

- “Normal” difficult patient
- Raise negative feelings from the clinician
- Failure to respond
- Psychosocial stressors
- Comorbid psychological disease
- Socially isolated
- Indigent patient
Patients may have their own views of illness and care that may not be in line with the provider’s perspectives.

What is a Difficult Patient?
## Grove’s Difficult Patient Groups

<table>
<thead>
<tr>
<th>Label</th>
<th>Identifying Features</th>
<th>Treatment Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent clinger</td>
<td>Escalating need for reassurance</td>
<td>Set limits with realistic expectations</td>
</tr>
<tr>
<td>Entitled demanders</td>
<td>Initially present as needy but soon become aggressive and intimidating</td>
<td>Do not react to anger. Acknowledge situation and discuss realistic expectations</td>
</tr>
<tr>
<td>Manipulative help-rejectors</td>
<td>Ungrateful, pessimistic about tx outcome</td>
<td>Paradoxically advocate adopting a skeptical attitude toward tx and schedule regular appts.</td>
</tr>
<tr>
<td>Self-destructive deniers</td>
<td>Tend to engage in behaviors that thwart attempts to improve condition (smoking, drinking, etc)</td>
<td>Avoid vengeful feelings and punishment but should instead focus on and tx underlying depression</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BEHAVIORAL</th>
<th>SOCIAL</th>
<th>PHYSIOLOGICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personality D/O</td>
<td>Personality D/O</td>
<td>Analgesic Abuse Syndrome</td>
</tr>
<tr>
<td>Somatoform D/O</td>
<td>Somatoform D/O</td>
<td>Altered Pain Responses</td>
</tr>
<tr>
<td>Bipolar D/O</td>
<td>Bipolar D/O</td>
<td>Opioid Metabolism</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Anxiety</td>
<td>Pain Mechanism</td>
</tr>
<tr>
<td>Depression</td>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Schizophrenia</td>
<td></td>
</tr>
<tr>
<td>Substance Use</td>
<td>Substance Use</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trust / Past Exp.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Concepts of Illness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Concepts of Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fears</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stoicism</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family / Friends</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Stigma</td>
<td></td>
</tr>
</tbody>
</table>
Causes of Difficult Pain Patients

- Biological
  - Hard to treat syndromes
- Psychological
- Sociological
- Unrealistic Expectations
- Physician characteristics
- Healthcare system related
TABLE 1  *Types of difficult patients* (in descending order of relative frequency)

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Violent, aggressive, verbally abusive</td>
</tr>
<tr>
<td>2.</td>
<td>Unsolved repeated complaints</td>
</tr>
<tr>
<td>3.</td>
<td>Multiple complaints - ‘shopping list’</td>
</tr>
<tr>
<td>4.</td>
<td>Psychosomatic patients</td>
</tr>
<tr>
<td>5.</td>
<td>Complaining, never satisfied</td>
</tr>
<tr>
<td>6.</td>
<td>Seeking secondary gain</td>
</tr>
<tr>
<td>7.</td>
<td>Manipulative, lying</td>
</tr>
<tr>
<td>8.</td>
<td>‘Everything hurts’</td>
</tr>
<tr>
<td>9.</td>
<td>Having a high anxiety level</td>
</tr>
<tr>
<td>10.</td>
<td>‘Pain in the neck’</td>
</tr>
<tr>
<td>11.</td>
<td>Demanding, boundary - busting, exploiting the doctor</td>
</tr>
<tr>
<td>12.</td>
<td>Angry at the doctor</td>
</tr>
<tr>
<td>13.</td>
<td>Un-cooperative</td>
</tr>
<tr>
<td>14.</td>
<td>Difficult psychiatric patient</td>
</tr>
<tr>
<td>15.</td>
<td>Drug addict</td>
</tr>
</tbody>
</table>

What is a “Difficult Patient”?

*Steinmetz D, Tabenkin H. Family Practice 2001; 18: 495-500.*
Borderline Personality Disorder

- Pervasive pattern of instability of interpersonal relationships, self-image, and affect with marked impulsivity.
- Most difficult disorder clinicians face
- 18% prevalence
- May amplify the pain or be the sole cause
- See things as “black and white” and easily go from different extremes of emotions
Symptoms of BPD

The symptoms of BPD can occur in a variety of combinations, and individuals with the disorder have many, if not all of the following traits:

- Fears of abandonment
- Extreme mood swings
- Difficulty in relationships
- Unstable self-image
- Difficulty managing emotions
- Impulsive behavior
- Self-injuring acts
- Suicidal ideation
- Transient psychotic episodes
Dealing with the Borderline Personality Disorder Patient

• Early recognition is important

• Medications under the direction of a psychiatrist may help

• Dialectical behavioral therapy (DBT)
  – Teaches them to control and not react to their emotions

• Try managing conservatively as response to treatment can be difficult to assess

• Try to be understanding of emotional extremes and do not react negatively
Affective Disorder

• 30-50% of pain clinic patients have major depression or anxiety disorders
• May emerge in the course of treatment, especially if they are not responding
• Results in poor coping, poor motivation
• Tend to blame the physician for lack of response to therapy
Dealing with the Affective Disorder Patient

- A combination of psychotropic medication and psychotherapy most effective
- Embrace a biopsychosocial approach
- Important to:
  - Explore psychosocial history prior to pain problem
  - Use language that they understand
  - Educate on both the physical and emotional aspects of their pain
Somatization

- Self perpetuating somatic symptoms in the absence of organic pathology
- Multitude of unexplained symptoms in the presence of normal results from diagnostic tests and physical examination
- Catastrophize
- High disability and healthcare utilization
- “Sick Role”
- Difficult to diagnose
- Be careful in labeling patients
Dealing with the Somatisizing Patient

- Honest discussion
- Cognitive behavioral therapy
- Antidepressant medication
- Psychiatric consultation
- Very conservative treatment of pain
Hostile Patient

- Common in pain clinic settings
- Yell, become verbally and maybe physically abusive
- Can present a very stressful situation for staff members
Dealing with the Hostile Patient

- Remain calm and collected
- Handle problem in private
- Listen to patient’s complaints
- Convey kindness and reassurance
- Try to reach a solution
- Document encounter

Five A’s for Dealing with Hostile Patients

• Acknowledge the problem
• Allow the patient to vent uninterrupted in a private place
• Agree on what the problem is
• Affirm what can be done
• Assure follow-through

– Dealing with Difficult Patients in Your Pain Practice.
  Wasan AD et al. Reg Anesth and Pain Med. 30:184, 2005
Suicidal Patient

- Suicidal ideation and attempts common among pain patients
- Passive death wish
  - Wish they were dead
- Suicidal intent
  - Actively want to end life
- Suicidal intent with a plan
Suicidal Assessment and Treatment Planning Issues

- Evaluate suicidal intent and lethality
- Establish existence of feasibility of a suicidal plan
- Identify evidence of self-destructive behavior and past suicide attempts
- Attempt to establish an alliance with the patient
- Consider a contract for safety
- Refer to mental health specialist with training in suicidal evaluation and treatment and/or escort to the ER
- Document communication with patient and treatment strategies

Substance Abuse Disorder

- 10-16% of patients treated in general practice and 25-40% of hospitalized patients have prior problems related to drugs or alcohol.
- Prior history of substance abuse disorder requires careful assessment and monitoring if using opioids.
Medical History: hepatitis C, HIV, TB, cellulitis, sexually transmitted diseases, elevated liver function tests, etc.

Social History: motor vehicle or fire-related accidents, DUIs, domestic violence, criminal history.

Psychiatric History: personal history of psychiatric diagnosis, outpatient and/or inpatient treatment, current psychiatric medications.
High Risk vs High Worry

**High Risk =**

**Risk of Adverse Medical Effects**
- COPD
- Dementia
- BPH
- Unstable gait
- Hazardous environment
- Pre-treatment constipation
- Hepatic insufficiency
- Low blood pressure
- Sleep apnea
- Methadone deaths

**High Worry =**

**Risk of Abuse Behaviors**
- History of drug or alcohol abuse
- Criminal history
- Unclear cause of pain
- History of multiple pain clinicians
- Multiple tattoos
- Unstable home environment
- Too ingratiating; too demanding
- “Gut feeling”
Screening Tools To Assess Risk Level for Use of Opioids

- Drug Abuse Screening Test – DAST
  - 20-item questionnaire
- Opioid Risk Tool – ORT
  - 5-item clinical review
- Screener and Opioid Assessment for Patients with Pain – SOAPP
  - 5-, 14-, or longer 24-item questionnaire
Aberrant Drug-taking Behaviors

Major
- Selling prescription drugs
- Prescription forgery
- Stealing or borrowing another patient’s drugs
- Injecting oral formulation
- Obtaining prescription drugs from nonmedical sources
- Concurrent abuse of related illicit drugs
- Multiple unsanctioned dose escalations
- Recurrent prescription losses

Minor
- Aggressive complaining about need for higher doses
- Drug hoarding during periods of reduced symptoms
- Requesting specific drugs
- Acquisition of similar drugs from other medical sources
- Unsanctioned dose escalation 1–2 times
- Unapproved use of the drug to treat another symptom
- Reporting psychic effects not intended by the clinician

Always Plan for Potential Exit Strategy

• Criteria for tapering emphasized in the initial patient agreement
  – documentation of lack of pain reduction and/or lack of functional improvement
  – documentation of opioid medication or prescription misuse or abuse
  – positive urine screen test for any illegal substance
  – failure to comply with all aspects of treatment program

• Distinguish between abandoning opioid therapy, abandoning pain management, and abandoning patient

• Taper off opioid therapy, with or without specialty assistance
Noncompliance

• Noncompliance can occur with medications, rehab, psychological referral or lifestyle changes

• Causes:
  – Non acceptance of treatment plan
  – Unrealistic expectations
  – Social issues
    • Financial, time, work, etc.
  – Addiction
Noncompliance Management

- Consider modifying treatment plan
  - May coax the patient into acceptance of original plan
- Educating the patient on importance of treatment plan to success
- If patient unwilling to comply, inform them that no further appointment will be made unless they are ready to accept treatment
Noncompliance With Drugs of Dependency

• There should be a low tolerance for noncompliance with drugs of dependency
• Persistent noncompliance should result in drug tapering
  – Achieved with a well defined tapering schedule to avoid withdrawal
  – Patients who cannot comply with a taper should be warned that no further refills will be provided and given locations of detoxification program
  – Carefully document in medical records
  – DO NOT BE HELD HOSTAGE!!
Effect of Litigation on Chronic Pain

• Secondary Gain
• Pain likely to improve once litigation resolves.
• Avoid aggressive invasive therapies if patient in litigation
• Unlikely patient is malingering
  – Stress/anxiety of litigation drives the pain
Marital, Family, Work Dissatisfaction

- Social turmoil can lead to increase pain and poor response to therapy
- Beware that these patients may use pain medications (especially opioids and benzos) to treat emotional disturbances
- Work dissatisfaction can lead to secondary gain of disability
Should Pain Physicians Sign Disability Papers?

• Probably not as it is counterproductive to pain treatment
• Pain in and of itself is not a reason for disability
• Reasonable to provide work restrictions and accommodations
Poor Lifestyles

- Pain is more common in patients who do not regularly exercise, eat appropriately and get enough sleep.
- Lifestyle changes should be a part of every pain treatment plan.
- Compliance with lifestyle changes is just as important as compliance with medical therapies.
The Patient Who Wants to be “Fixed”

• These patients usually have unrealistic expectations and do not understand the limitations of modern medicine

• Attempt an honest discussion with the patient and adjust expectations

• Failure to adjust expectations can lead patient down a path of excessive treatment and failure
Physician Factors

- Difficult patients are not always the fault of the patient
- Physicians who are less empathetic are more likely to perceive patients as difficult
- Do not take behavior personally but recognize that it is how patients react to other situations
- Do not let patient behavior drive poor decisions
The ‘Silver Lining’:

Older, more experienced doctors:

- Reported fewer difficult Pts.
- Coped better with wide variety of Pts.

What is a Difficult Patient?

Components of Every Patient Encounter

- Engage
- Empathize
- Educate
- Enlist
- End

Health Care System Factors

- Access
- Delays
- Authorization
- Copays
- Clinic Time
- Phone
Dismissing a Difficult Patient

- Inform the patient why they are being dismissed
  - Face to face and with a formal letter
  - If concern over hostility, only a letter is needed
- 30 days notice is adequate
- Refer to local Medical Society for list of other practitioners they can choose from
- Provide taper schedule for drugs of dependency
- If the patient is a part of a contracted health plan with your group, the group Medical Director will need to terminate
The Difficult Patient with Implantables

• Not as common as these patient undergo more psychological screening before implant and tend to have more of an established strong physician-patient relationship

• If noncompliance or unacceptable behaviors arise, therapy can still be discontinued
  – Easier done with stimulation
  – More challenging with intrathecal therapy
Weaning Intrathecal Therapy

- Scheduled weekly visits with titration down until pump off
- If patient is noncompliant, at next pump refill, turn the pump off and provide oral medications to cover drugs of dependence with a weaning schedule
- Explant of the system has to have the consent of the patient
Interventional Therapies that go Wrong

• Not uncommon for patients to report increase pain after interventional procedures
• In the absence of “red flags”, reassurance is the best remedy along with a short course of analgesics if necessary
• In the case of serious injury, remain level headed and approach the case as you would any patient and do not get defensive
• Do not let threats of litigation intimidate you. Remain calm and manage the patient’s problem as indicated.
• Risk Management may need to be contacted
• Carefully document but do not try and place any blame in the medical record
Summary

• The “difficult pain patient” is often a two-way street and the provider can be just as much at fault.
• Understanding the reasons behind the behavior can often defuse the situation.
• However, there are times when the line must be drawn with continuing unacceptable behavior. Even when this occurs, rationale approaches are effective in terminating the situation calmly.