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.

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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,

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

Table 1. Summary of Grove's Difficult Patient Groups

Label	Identifying Features	Treatment Strategies
Dependent clinger	These patients have an escalating need for reassurance and over time become increasingly more helpless.	The clinician should set appropriate limits with realistic expectations, including the use of clear verbal and written instructions.
Entitled demanders	These patients initially present as needy but soon exhibit aggressive and intimidating behavior.	The clinician should not react to their anger but should instead acknowledge the situation and discuss realistic expectations.
Manipulative help-rejectors	These patients are generally ungrateful for any help that is offered and are often pessimistic about treatment outcome.	The clinician should paradoxically advocate adopting a skeptical attitude toward treatment and schedule regular appointments.
Self-destructive deniers	These patients tend to engage in behaviors that thwart attempts to improve their condition (e.g., excessive drinking and smoking).	The clinician should avoid vengeful feelings and punishment but should instead focus on and treat the underlying depression.

of the primary tasks a pain physician faces as a healer are to foster realistic expectations for treatment success, to convey that patients are not completely broken by pain, and to encourage patients to appreciate that improvements in their pain allow them to carry on a satisfying life. Patients prone to difficult behavior who perceive that the pain physician's role is to cure them completely will tend to react with frustration when pain persists. By acknowledging the inadequacies of the health-care system, demonstrating empathy for patients' pain, and acknowledging the difficulties they may have faced merely in getting a referral to a pain center, physicians can allay difficult behaviors, build trust and confidence in the doctor-patient alliance, and encourage treatment compliance.

How Important Is the Doctor-Patient Relationship?

In their book *Field Guide to the Difficult Patient Interview*, Platt and Gordon[11] state that the best predictor of patient adherence is the doctor-patient relationship itself. Having a healthy relationship based on trust, empathy, and confidence in the physician is the first step in preventing patients from becoming difficult. All too often, patients become difficult because of perceived deficiencies in the relationships with their physicians. Failure to improve may fuel a patient's frustration, but it seldom proves to be the sole reason for the development of difficult behaviors and interactions. A number of factors can be addressed in an effort to foster a relationship in which the physician is seen as a healer and ally, not merely a service provider. Appreciating the patient's perspective and empathic listening are key skills to improving the doctor-patient relationship, which have been identified in qualitative research studies.[13,14]

As an illustration, below is an excerpt from an interview with a 25-year-old woman with a clinical diagnosis of complex regional pain syndrome (CRPS) of the lower limb after a knee injury sustained in a motor vehicle accident. She describes her treatment process and the interactions with the physician that fueled her pain, which made an already difficult sympathetic block even worse.

> My primary care physician said I should see a pain specialist. I didn't realize that on the first day, the doctor was going to do a procedure. He had me set up for a sympathetic nerve block. He had me face down and I was watching a screen. He had supposedly doped me up to the point where I was supposed to be sleeping, but I wasn't sleeping. I was wide-awake and I hurt. After the procedure, they put me in the recovery room, and at that point I began to feel a low burn. I was told that I was not supposed to be feeling anything. I told the nurse that my leg was getting really painful. From then on, my leg felt like it was being dipped in acid. That is the only way I can describe it. Nobody could touch it. Every time anyone even walked past I went into absolute hysteria because the movement of air hurt my leg so bad. The doctor finally came in and said, "I can't stop it. You are having a block. You are numb, it is going to take time to get rid of it. I can't do anything." I told him that I didn't want any other procedures but that I couldn't stand the pain. He said that he couldn't do anything else for me.

Although this patient may have been ill prepared for her nerve block and had a perplexing reaction to it, she did not think that the physician understood what she was feeling and felt that her experience was discounted. The patient's perception that his or her unique perspective has been appreciated, including what he or she had been through and is currently experiencing, is important in maintaining a good doctor-patient relationship. Even if the pain physician cannot alleviate the pain, difficult situations can be avoided or ameliorated if the patient feels that the physician is listening and understands. How a patient perceives his or her illness experience is most important. This perception influences health behavior and colors all future interactions with the health-care provider. The above example of an adverse reaction during and after a procedure

highlights how a greater attempt to address expectations, and to understand and acknowledge the validity of the patient's reactions, could have made a difficult case go more smoothly. Her maladaptive style of reacting very emotionally in the face of pain was heightened when she felt the physician did not take her complaints seriously.[15] If the physician had acknowledged the patient's report of pain, reassured her that he would not abandon her, that more could be offered for her pain, and that her pain would likely improve over time, he could have alleviated some of her distress and improved her outcome.

What if My Personality Does Not Mix Well With Difficult Patients?

Not all clinicians are adept at handling difficult patients, but this ability can be improved. Coulehan et al.[16] identified ways for a clinician to build empathy and, in turn, defuse problematic encounters with difficult patients. Asking questions such as "Is there anything else?"; using clarifying statements such as "Let me see if I have this right."; and responding with feeling statements such as "I can imagine how this might feel" can be helpful. Every practitioner faces difficult patients, and a conscious attempt at being empathic will help to avoid personality conflicts.

Gillette[17] recommends not only that health professionals continually assess and understand their own strengths and weaknesses but also that they improve basic communication skills. The physician can reduce the likelihood of escalating problems by being patient, proactive, and nonjudgmental. Physicians also benefit from hiring support staff who are pleasant and adept at dealing with interpersonal problems. For certain patients, scheduling regular visits, encouraging the patient to take an active part in his or her care, and working with the patient's family will thwart difficult encounters, irrespective of a physician's unease in dealing with difficult patients. Regular visits convey the message that the patient should deal with pain flares and not respond to them as crises. Such visits establish a set period when the physician will be most available to them, which reassures patients that their physicians care about their progress. Encouraging active participation in physical rehabilitation or other treatments shifts the burden of improvement from being solely on the physician. A patient's family can reinforce this idea and help monitor compliance.

How Else Can I Improve My Empathic Listening Skills?

Intrinsic to the healing process is the perception by patients that their health-care providers are listening and genuinely appreciate their suffering. As outlined above, difficult patients are often those who have difficulty not only with the level of their pain but also with their pain physician. Simple questions can be powerful tools in conveying a physician's empathy for and appreciation of a patient's suffering. Questions such as "Is having chronic pain a lot of work for you?"; "How is your life changed because of the pain?"; and "What have you lost as a result of having chronic pain?" acknowledge that the patient is experiencing extreme difficulty and loss, and that they are trying their best to cope effectively.

The work of illness is a powerful metaphor for patients in describing their hardships. In *The Social Organization of Medical Work*, Anselm Strauss and coauthors[18] discuss the difficult daily routines of hospital inpatients. They suggest that routines such as being awakened for blood draws, tolerating the burning pain of an I.V. dilantin drip, and trying to sleep at night in a room with coughing pneumonia patients is stressful, disruptive, and requires tremendous effort. These observations led the authors to propose that adapting to illness can be viewed as "work." An excerpt from an interview with a patient with CRPS illustrates this concept:

> MD—Do you think having chronic pain is like a kind of work?
>
> Patient—Oh yeah, you might say that it is work, damn hard work.
>
> MD—What are some of the things?
>
> Patient—It makes it harder to dress because I can't button and unbutton my shirt. It's hard to comb my hair and hard to undress at night and then I have to take pills every four hours. I wake up in the middle of the night and I have to take the pain medication. Now I am taking medication day and night and I get constipated and have to take stuff for that. It's a hell of a lot of work.

The above passage contextualizes the effects of chronic pain on activities of daily living (ADLs). The clinician must appreciate the extent to which a patient's life is modified by a chronic, painful condition. A question such as "Is getting better from pain like doing a kind of work?" goes a long way toward showing patients that their physicians understand their suffering. Difficult patients generally tend to feel relieved when their physicians express interest in their lives. By framing their illness experience in terms of "work," the empathic physician is acknowledging the effort patients put forth in trying to get better, thereby reassuring them that they are not to be blamed for a lack of improvement.

How Does Psychiatric Comorbidity Affect Difficult Patients?

Despite a physician's best efforts at improving skills as a healer and empathic listener, significant

psychopathology may make patients unavoidably difficult. Psychopathology affects between 30% and 50% of patients seen in academic and community pain centers.[19,20] The majority of these patients developed psychopathology after the onset of pain.[6] The main areas of psychopathology associated with chronic-pain patients include personality, affective, somatoform, and substance abuse disorders. The pain physician needs to recognize when the patient has a psychiatric problem and consider referring the patient to a psychiatrist or psychologist and/or beginning treatment with psychotropic medication. Studies indicate that untreated or undertreated psychopathology is the single most important factor in poor pain-treatment outcome, regardless of the treatment modality.[21,22] Pain patients with comorbid psychiatric disorders report higher pain ratings and show greater pain-related disability than do other patients. Furthermore, these patients more often exhibit a blunted response to pain medications, neural blocks, and physical rehabilitation than do those without psychopathology.

Some patients have personality disorders that can account for and magnify difficult behavior. A personality disorder, as described in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (DSM-IV),[23] is "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture" (p 629). Personality-disordered individuals present with a pervasive pattern of maladaptive emotional and cognitive reactions to daily events or challenging circumstances. Patients who appear odd or eccentric may be paranoid or meet criteria for schizoid or schizotypal disorders. Patients who appear dramatic, emotional, or erratic may have an antisocial, borderline, histrionic, or narcissistic personality disorder. Those patients who appear to be extremely anxious or fearful may have an avoidant, dependent, or obsessive-compulsive personality disorder. In a study comparing difficult patients with control subjects, Schafer and Nowlis[24] found that difficult patients were more likely to have personality disorders and posited that dependent personality disorders are especially difficult. The majority of pain patients have minor forms of a personality disturbance that manifest in a general tendency to respond to stress with negative emotions, such as fear, anxiety, sadness, anger, and impatience.

How Do I Deal With a Borderline Personality Disorder?

Perhaps the most difficult personality disorder a clinician faces in a pain practice is borderline personality disorder (BPD). The diagnostic criteria of BPD include a pervasive pattern of instability of interpersonal relationships, self-image, and affect, with marked impulsivity.[23] Sansone et al.[7] explored the prevalence of BPD among primary-care patients with various chronic-pain syndromes by using the Personality Diagnostic Questionnaire, the Self-Harm Inventory, and a diagnostic interview for borderline patients. They found that 18% of pain patients scored positively on all 3 measures for BPD. The authors suggested that the emotional self-regulatory disturbances in these patients either amplify the nociceptive components of chronic pain or are, by themselves, the basis for a purely somatoform pain syndrome.

BPD encompasses a pattern of poor regulation of powerful emotions.[23] These patients have an intense desire to be valued and to idealize authority figures, such as their pain physicians. BPD patients easily become disillusioned when faced with reality and then rapidly shift to despair; they become distraught, feel abandoned and depressed, and may even become psychotic. They are sometimes suicidal and may have a long history of suicide attempts. These patients tend to be impulsive, to succumb easily and quickly to rage and despair, and to distort reality. Medications can be useful, along with types of cognitive/behavioral therapy, the most effective of which is dialectical behavioral therapy (DBT). DBT emphasizes that the patient will always have powerful emotions and that the key to improvement is not to react in familiar, maladaptive patterns to such emotions. Although early recognition of this disorder helps to avoid difficult situations, avoiding procedures on these patients may also prevent difficulties. Because the level of affective distress is high in BPD patients, the nociceptive or neuropathic components of a pain syndrome that may respond to an interventional procedure can be difficult to determine. Procedures may temporarily worsen pain, and if a BPD patient is prone to self-mutilation or suicidal behavior in the face of distress, an elevated risk of self-harm may occur after a procedure.

What if the Patient Presents Principally With an Affective Disorder?

Among patients attending pain clinics, 30% to 50% have a major depressive or anxiety disorder.[6,9] Common symptoms are low mood, increased worry, and irritability. Although such symptoms are most apparent to the spouse or family members, they may emerge in the physician-patient encounter. Depressed or anxious patients may "lash out" at their pain physicians, blaming them for overwhelming pain and failure of treatment. Affective disorders make coping with pain exceedingly difficult. Although a patient may be adjusting to pain and making reasonable at-

tempts at functional improvement when first evaluated, the development of an affective disorder may manifest as poor motivation to remain active and a perceived intensification of pain in the absence of changes in pain pathology. Suggestions by the pain physician that their pain cannot be "cured" may be met by frustration and anguish over the anticipation of a life with unbearable pain. The combination of psychotropic medications and psychotherapy yields the best treatment success for both depression and anxiety disorders. Epstein et al.[25] recommend that to avoid blaming the patient, the clinician should embrace a biopsychosocial perspective and attempt to understand the patient's experience of illness. They suggest that the clinician explore the patient's life context (things that led up to and perpetuate the presenting problem), find mutually meaningful language (use language that the patient can understand), and normalize the patient's bodily experience of distress (help explain the physical and emotional reactions to the condition).

How Do I Treat a Patient I Believe to Be Somatisizing?

Barsky and Borus[26] used the term "functional somatic syndrome" to characterize individuals with a perceived serious medical problem with self-perpetuating somatic symptoms, in the absence of organic pathology. These individuals believe that they have a serious disease that will likely get worse. They often have psychiatric comorbidity and portray their conditions as catastrophic and disabling. They present with a "sick role" and significant disability, despite a lack of anatomical or functional pathology. Righter and Sansone[27] suggest a number of treatment strategies for difficult patients who show normal results from physical examination and diagnostic tests, yet have multiple unexplained symptoms, patterns of high healthcare utilization, and problematic family and social history. To offset continued problematic behavior and failed treatments, they recommend honest discussions, behavior management strategies, cognitive-behavioral therapy, antidepressant medication, and psychiatric consultation.

What Should I Do With a Hostile Patient?

A 35-year-old man was referred for treatment of his low back and right lower extremity pain following failed back surgery. He had a work-related accident and was diagnosed with an L4-5 radiculopathy. Physical therapy, epidural steroid injections, and non-opioid medications were unsuccessful. He was prescribed high-dose opioids, but continued to report 7/10 pain. He had a history of alcohol dependence and family conflicts. He came to the clinic stating that he had lost some of his prescription medication and was told that additional medication would not be prescribed until his scheduled due date. He became belligerent, said that it was not his fault, demanded to speak with patient relations, and threatened to sue the treating physician. Fearful that he might become combative, a staff member called security.

Table 2. Five A's for Dealing with Hostile Patients

1. Acknowledge the problem.
2. Allow the patient to vent uninterrupted in a private place.
3. Agree on what the problem is.
4. Affirm what can be done.
5. Assure follow-through.

Hostile patients are those who may yell, be verbally abusive, or even physically threaten the physician or office staff, similar to the case above. A risk management article produced by Princeton Insurance[28] recommended the following steps when facing a hostile patient. First, remain calm and collected. By maintaining a relaxed posture and respecting the patient's personal space, you can set the stage to defuse a difficult situation. Second, handle the problem in private. Gently redirect the patient into a room away from the reception area. This action will be less disturbing to others and can reduce the chances of a hostile outburst. Third, listen actively to the patient's complaints. By paying attention, maintaining eye contact, and letting the patient vent, you create a greater likelihood that some resolution can be reached. You are less likely to resolve a problem for a hostile patient until that person has vented without interruption. Fourth, convey kindness and reassurance. Although this response may be extremely difficult at the peak of an outburst, acknowledge the patient's feelings and offer little resistance. This behavior lets the patient know that you want to help. Fifth, try to reach some solution and conclude the meeting with willingness to follow up on any recommended action. Sixth, document any hostile encounter. You may not need to include this information in the patient's record, but a detailed description of what happened may prove valuable at a later date. Remembering these steps as the 5 A's for dealing with hostile patients, as shown in Table 2, may be helpful. Unfortunately, sometimes a satisfactory solution cannot be reached, and assistance from security is needed. If the physician or staff members feel threatened by a hostile patient and think the patient may become violent, security should be called to escort him or her from the clinic. This action is crucial when staff feel threatened and in need of protection. Only in situations of imminent self-harm or harm to others should clinic staff attempt to restrain the patient themselves.

What if the Patient Is Suicidal?

A 45-year-old woman developed myofascial low back pain after slipping on a rug and falling at home. She was

Table 3. Suicide Assessment and Treatment Planning Issues

1. Evaluate suicidal intent and lethality.
2. Establish existence and feasibility of a suicide plan.
3. Identify evidence of self-destructive behavior and past suicide attempts.
4. Attempt to establish an alliance with the patient.
5. Consider a contract for safety.
6. Refer to mental health specialist with training in suicidal evaluation and treatment and/or escort to a hospital emergency room for psychiatric evaluation.
7. Document communication with patient and treatment strategies.

NOTE. For full list of guidelines, see www.rmf.harvard.edu/reference/guidelines/suicideprev/

unable to tolerate most medications and was not seen as a surgery candidate. She wore a back brace, walked with a cane, and was disabled secondary to her pain. She frequently called the clinic, turned up without an appointment, and sent long emails to her physician. She was eventually told that she needed to limit her calls and messages and come to the clinic only at her designated appointment times. She was subsequently admitted to the hospital after a serious suicide attempt. She claimed that her treating physician had neither taken her seriously nor responded to her desperate pleas for help.

At some time during their careers, pain specialists will likely encounter patients who make serious suicide attempts,[29] similar to the case above. Suicidal ideation and suicide attempts are common among chronic-pain patients.[9] Not addressing suicidality is clinically unfeasible and ethically inappropriate. Distinctions must be drawn among patients who wish they were dead (passive death wish), who actively want to end their life (suicidal intent), and who have a specific plan to do so (suicidal intent with a plan). Care providers should not hesitate to ask patients about possible suicidal ideation and for clarification of intent. Such questioning will not increase the chances of self-harm. Most patients appreciate knowing that their providers are concerned about their lives and well-being, and this knowledge in itself can decrease the chances of attempted suicide. Suicidal intent should be taken seriously, despite any suspicion that the patient is engaged in attention-seeking behavior (see Table 3 for evaluation guidelines). Coordination with a licensed mental-health professional who has training in managing suicidal patients is essential. Suicide attempts should be discussed openly with patients, and, in some cases, a written comprehensive treatment plan and an agreement with the patient to guarantee their safety may be needed. All encounters and behaviors should be well documented.

Although difficult patients who progress to a suicidal crisis may present the greatest challenge to a health-care provider, patients in crisis should not be abandoned. Rather, seeking coordination with mental-health professionals and establishing a comprehensive treatment team becomes essential. Patients should be informed that hospitalization may be considered in emergency situations and can become an integral part of a comprehensive pain treatment plan. Treatment recommendations must be clear, and careful monitoring of prescription medications should be a regular part of follow-up visits. Patients must be informed of the specific limits of confidentiality and the necessity of active consultation with colleagues. Issues regarding suicide and treatment planning are presented in Table 3.

What Should I Do With a Patient Who Has a Substance-Abuse Disorder?

A 32-year-old male was diagnosed with right upper extremity complex regional pain syndrome after sustaining a crush injury. He had multiple surgeries and failed trials of nerve blocks, TENS, and physical therapy. He was managed over a long period on sustained- and immediate-release morphine. He frequently showed up late for his appointments and had episodes of lost medication. A random urine toxicology screen revealed evidence of cocaine use. He insisted that this was only a one-time occurrence because of a flare-up of his pain and he would not be able to tolerate being taken off his pain medication. He asked to be given another chance.

Chronic-pain patients have a high risk of substance abuse, and determining an individual's potential for substance abuse is important.[30,31] Opioid abuse is characterized by an overwhelming focus on opioid issues in combination with problematic behaviors such as a pattern of early refills, lost prescriptions, and illicit substance use, as demonstrated in the case above. Addicted patients often report a craving for opioids and take more medication than prescribed.[30,31] Studies indicate that 10% to 16% of patients treated in a general practice and 25% to 40% of hospitalized patients have prior problems related to drug or alcohol addiction.[32] All patients should be asked about a substance abuse history as part of their initial evaluation, even among those who appear at the outset to be at a low risk for opioid addiction.

If opioids are being considered, a more detailed assessment of the risk of opioid abuse should be performed. The pain physician can assess the risk of aberrant drug behavior through attention to several predictive factors. A prior history of addiction to any substance, family history of addiction, illegal activities, and major psychopathology are predictive of developing prescription opioid abuse.[33,34] For those patients at a high risk for opioid abuse, either not prescribing opioids or careful monitoring, consisting of biweekly prescriptions, regular physician visits, and random urine toxicology screens should be instituted. In conjunction with the pain physician's assessment, patients who are prescribed opi-

oids for pain and who have any risk of medication misuse should also complete a screening questionnaire to determine opioid abuse potential (e.g., SOAPP[35] and PDUQ[36]). Having clear clinic guidelines and having all patients complete an opioid therapy agreement are essential.[37] Setting limits and clarifying expectations are often critical to the success of the contract. Documentation is an important risk management strategy, and decisions and rationale for prescribing opioids should be included in this documentation.

How Do I Handle Noncompliance?

Often, difficult patients may reject prescribed treatments through noncompliance with medications, physical rehabilitation, or lifestyle modifications. These patients may not be ready to make the changes necessary for improvement and may express their unwillingness to accept the treatment plan through noncompliance and maladaptive behaviors. The first step to solving this problem is to modify the treatment plan. Perhaps the estimation of their abilities and motivation was overly optimistic, or perhaps the patient has good reasons for noncompliance. Modifying the prescription of medication, physical rehabilitation, and recommended lifestyle changes may coax patients into complying. If this attempt fails, motivation may be elicited by informing patients that adherence to these modalities is instrumental to their improvement and a necessary condition for the continuation of treatment. Although patient preferences for treatment should generally be respected, for some pain patients, this indulgence can be countertherapeutic. An insistence on following the treatment plan can be justified by underlining the importance of mutual respect and patient cooperation. If patients are not ready or willing to comply, they can be informed that additional appointments will be scheduled only when they are ready to accept the recommended treatment plan. Careful documentation is always important in a decision to discontinue treatment, even if it is temporary.

What Are My Legal Obligations in Dismissing a Difficult Patient?

A difficult patient will rarely have to be dismissed or "fired" from a practice. However, in some situations, "firing" a patient is the only option, such as an opioid-addicted patient who refuses treatment for his or her addiction and continues to ask for prescriptions, or a patient who is repeatedly hostile. For such cases, several steps have been recommended.[38] First, inform the patient of the reasons you can no longer treat him or her. This action is usually carried out in both a face-to-face visit and a formal letter. If confronting the patient is too difficult or could lead to a significant escalation of problems, only sending a letter is acceptable. You can specify that, 30 days after receiving the letter, the patient will no longer be admitted to your practice. Second, you must give the patient names of other providers or contact information for the local Medical Society, from which he or she can obtain a list of providers. Last, at discharge, you must give the patient a tapering schedule along with a prescription for medications that require a taper, such as opioids, benzodiazepines, anticonvulsants, or antidepressants.

Conclusions

The "difficulty" with difficult patients has less to do with such patients' behaviors themselves and more to do with the feelings their behaviors evoke in their providers. Frustration, anxiety, guilt, or dislike on the part of patient or provider can inhibit or even damage the doctor-patient relationship, and effective management of such emotions is critical to the treatment of pain. Working well with difficult patients depends upon the physician's willingness to understand the reasons behind the behaviors that give rise to difficult feelings, as well as his or her ability to intervene in these behaviors in a way that is likely to defuse their negative impact and encourage both compliance and a greater sense of safety and efficacy on the part of the patient. Understanding the experience of chronic pain is important in evaluating any patient but crucial in treating difficult patients. Demonstrating empathy, helping the patient to feel heard and understood, and enlisting his or her participation in treatment form the basis of successful care of difficult patients. Acquiring a greater sensitivity toward comorbid psychopathology and certain patterns of problematic behavior, such as hostility, suicidality, aberrant drug behavior, and chronic noncompliance, and developing the skills necessary to address them with greater confidence can improve the experience of difficult patients and yield the greatest chance of success.

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