

## The Difficult Patient in Pain

# The War on Pain

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The good doctor decides whether or not to sign the patients' disability forms

## The Unspeakable Truth about Being a Human Clinician: Hating the Patient

- Not all patients are lovable or even likeable
  - Only a few & they probably suffer more than us
- Some situations are intolerable
  - We are only human
  - We also have defense mechanisms
- Awareness may help avoid stepping in do-do
  - Avoid harming others
  - Avoid harming ourselves

## Difficult Patients Suffer

- Most difficult patients suffer more than their clinicians
- Difficulties started before we get involved
- Ignoring strong negative feelings doesn't mean you don't have them
- Humor with difficult patients is a form of defense and not necessarily intended as ridicule

## Overview

- Some patients make us feel bad
  - its either us , them, or some combination
- Its not just us who suffer
  - Difficult patients are usually miserable
- What to do: Not Much New
  - **RECOGNITION**
  - **COMMON SENSE**
    - ~ Watch you vital signs
    - ~ Accept imperfection & cut the best deal
    - ~ When driving on slippery roads -- Slow Down

## Difficult

- Definition
  - ~ "hard to deal with, manage, overcome"
  - ~ "hard to understand" "hard to approach"
  - ~ "perverse or stubborn" "hampering or awkward"
  - ~ "causing pain or embarrassment"
- **Loving Labels (the fine art of pejorativity)**
  - ~ Crock, Looser, Faker, Scuzzball, Winer, Leach, Kvetch
  - ~ Thick Chart Syndrome, Black Holes, Manipulators
  - ~ GOMER, ?? Addict, Drug Seeker, Secondary Gainer
    - *Lipssett - Mt Auburn Hosp*

The Difficult Patient : Prevalence,  
Psychopathology, & Functional Impairment  
Hahn SR et al, J Gen Internal Med 1996, 11:1-8

- DDPRQ:
  - Difficult Doctor-Patient Relationship Questionnaire
  - 820 pts approached & 627 participated
- 159/627 w/DSM3r dx (25%)
  - 93/627 w/ subthreshold psychiatric dx (15%)
  - 40% w/some psych dx - similar to other large primary care populations
- 96/627 (15%) difficult by DDPRQ (score>30)
  - 1/6 pts were DIFFICULT

The Difficult Patient : Prevalence,  
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- Difficult pts:
  - almost 2x as likely to have Psych Dx
  - greater incidence with higher # mental d/o's
    - total # of mental d/o's proportional w/DDPRQ score
- Pts w/ Psych d/o's
  - 25% experienced as difficult
- Pts w/o Psych d/o
  - 8.5% experienced as difficult

The Difficult Patient : Prevalence,  
Psychopathology, & Functional Impairment  
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- Difficult Patients
  - MD's unenthusiastic to care for difficult pts
    - ~found them frustrating and time consuming
    - ~did not look forward to their return
    - ~felt ill at ease in their presence
    - ~felt manipulated
    - ~50% felt they wished pt would not return

### Difficult Pt in Ambulatory Clinic

Jackson and Kroenke Arch Int Medicine 159:1069-1075, 1999

- 500 adult patients presenting for physical Sx
- 38 physicians used DDPRQ
- 15% (74/500) of patients found to be difficult
  - more mental disorders
  - > than 5 somatic symptoms
  - increased severity of symptoms
  - increased rate of unmet expectations
  - reduced functional status
  - increased medical utilization but **less satisfaction with care**

### Moaz et al: The Nudnik Patient

- 10 Family Physicians
  - 42 difficult Patients
  - No specific criteria for difficult
- Studied Patients & Physicians
  - Beliefs about the reason for requiring treatment
  - Treatment expectations

### Moaz et al: The Nudnik Patient

- Beliefs:
  - Patients: problem largely Physical
  - Physicians: problem largely Psych & Fam/Soc
- Tx Expectations
  - Patients: Tx should be Physical (Med/Surg)
  - Physicians: Tx should be Physical (Med/Surg)

## Unappreciated Reactions

- We can't control every response to difficult patients
- Even those who specialize in monitoring themselves can't always do it
  - Yalom

- Groves JE: *Management of the borderline patient on a medical or surgical ward* Int J Psychiatry in Medicine 6(3) 1975
- Adler & Buie: *Countertransference Hate* Int J Psychoan Psychother 1:109 1972
- Maltzberger T and Buie M: *The hateful patient* Arch Gen Psych 30:625, 1974

## What Difficult Patients Do

- consume enormous time and effort
- staff friction
- non-compliant with or refuse treatment
- violent behavior, suicidal
- addiction
- threaten reprisal
- secondary gain, non-response

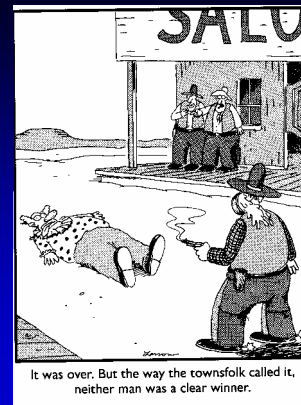
## Process: how do they do it

- impossible demands
- splitting (stimulate disagreement)
- dependent
- entitled
- intractable symptoms that are impossible to quantitatively diagnose or treat
- impulsive, rageful, passive, thankless

## Staff Response:

- Anger
- Alarm/freight
- Helplessness
- Vengefulness

~We all React!





## Types of Difficult Patients

(Groves)

- Dependant Clinger
  - Inexhaustible needs
    - ~ seductive & grateful while getting increased time and attention
  - Honeymoon period
  - Steady progression of demand
  - Caregivers ultimately feel aversion

## Types of Difficult Patients

(Groves)

- Entitled Demander
  - Arouse fear, anger, guilt
    - ~ Threatening demands
  - GUILT: *you guys are the doctors - why don't you know what's wrong and how to fix it*
  - Thin layer of insecurity & self-doubt
  - Mantra for the entitled patient
    - ~ "You deserve the best possible care"

## Entitlement

- The paradoxical equivalent of hope or faith in a normal person
  - Mirror image of the patient's true sense of self loathing
  - Often best to recognize this as a strength
- "entitlement is the patient's religion and must not be confronted blasphemously"*  
groves

## Types of Difficult Patients

(Groves)

- Manipulative Help Rejecters
  - Not grateful or appreciative
  - Pessimistic: nothing will help
  - Content but not indifferent
  - Getting better might undermine life
    - ~ avoid maintaining relationship by perpetuating illness
  - Caregivers become anxious & self doubting
    - ~ harder the caregiver tries >> Resistance
    - ~ watch for Depression, Anxiety d/o's

## Types of Difficult Patients

(Groves)

- Self-destructive Deniers
  - Not necessarily aware of death wish
    - ~ -slow suicide
  - Smoking COPDers, drinking cirrhotics, lipophilic CADers
  - Benevolent physicians feel conflicted
    - ~ maintaining life in self abusing dying patients
    - ~ physician is alone in trying to improve health
    - ~ watch for depression in pt and clinician

### Stereotype to Treatment Strategy: Eric Sohr: "The Difficult Pt" (Groves)

Stereotype	Mechanism	Clinicians emotion	Strategy
Dependent Clinger	pt w/inexhaustive needs MD w/ infinite supply	power, specialness later-aversion	limits freq visits
Entitled Demander	unaware that demands are due to dependency fear of abandonment	guilt, fear, worthless attack entitlement	preserve entitlement -right to care
Manipulative Rejecter	fears recovery will lead to abandonment and loss	inadequate, anxious overlooked treatable Dz	limit unreal expectations share pessimism
Self-destructive Deniers	patient resigned to failure pleasure in destruction	frustration, sadistic guilt over wish that pt may as well die	? pt has given up ? MDE, Psych ally w/ strengths

## Pain Games

taken from: Sternbach, Richard: *Pain Patients: traits and treatments*  
Academic Press, New York, San Francisco, London, 1974

- Cast of Characters
  - **Patients**  
who see themselves as **suffering**
  - **Clinicians**  
who see themselves as **treating** pain, suffering, or both

## Pain Games: the plot

- Interactions and negotiations:
  - › between two or more persons
  - › ulterior motive and payoff at the end
  - › no assumption that patient or clinician is acting consciously

## Gotcha

- Patient:
  - "Look how much I suffer; even the doctors can't figure out my pain" (**Hook**)
  - "I suffer too much to be responsible for anyone or anything" (**Line**)
  - "I can't go on without pain medicine and disability compensation" (**Sinker**)

## Basic Transaction

- Pain Patient: *I hurt, please fix me*
- Clinician: *I'll fix you*

After numerous procedures, failed therapeutic interventions, and further requests for relief the doctor admits failure. The basic transaction is complete with the following exchange:

- Pain Patient: *Another incompetent quack*
- Clinician: *Another crock*

## Home Tyrant 1 of 2

- Patient tyrannizes those at home by avoiding responsibility and gets a payoff from controlling behavior
  - false disability
  - tender loving care is appropriate and necessary in acute pain
  - tender loving care can be enabling and destructive in chronic pain

## Home Tyrant 2 of 2

- Pain Patient: *It's not that I don't want to , I can't*
  - put out the trash, have sex, go to work, etc.
  - the excuse with honor
- Spouse: *That's alright, I understand. I'll take care of it*
- False assumptions:
  - I can't really means I don't
  - Most chronic pain is not worsened by getting on with it

## The Professional

- The patient that gets paid for their illness
  - The professional patient loses their amateur status when paid for their role as a patient
- **Pain Patient:** *Fix me (but you will fail)*
- **Clinician:** *I'll fix you*
- **Pain Patient:** *How long before my pain is decreased so I can go back to work?*
- **Clinician:** *Hopefully Soon*
- **Pain Patient:** *Sign here*
- **Clinician:** *OK*

## The Addict 1 of 2

- Plot:
  - Patient expresses concern or even horror over taking addictive medicine but ultimately maneuvers to make offering them the lesser of evils
  - Patient protests too much & keeps taking analgesics

## The Addict 2 of 2

- **Pain Patient:**
  - *When the pain came I took the darvon you gave me and it didn't work so I took some Percocet my brother had and some codeine my orthopedist gave me last year, and it only eased the pain a little bit. I hate taking all those pills. Can't you cut a nerve or something?*
- **Clinician: (relieved)**
  - *I wish we could but let's find another analgesic since the others are not helping you. You won't become addicted if you follow the directions.*

## Difficult Patient: Secondary Gain

- Who doesn't have secondary gain?
- Dx of exclusion
- Professional secondary gain
  - when does labeling help the patient??
- Never withhold treatment solely on the basis presumed secondary gain

## Difficult Patients: Malingering, Factitious d/o, Conversion

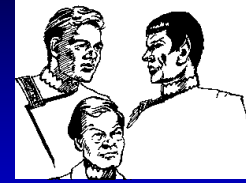
Disorder	Symptom Production	Motivation for Symptom
Malingering	Conscious	Conscious
Factitious Disorder	Conscious	Unconscious
Conversion	Unconscious	Unconscious

## Dx of Personality Disorder

- Usually Not Compliment
- Impossible to make Dx on only a few visits
- Persistent Patterns of Severe Dysfunction
  - don't confuse with personality traits
  - traits clarify with stress

## Personality STAR TREK

- Captain Kirk
- Doctor Bones
- Mr. Spock
- Evil Klingons
  - Males: no conscience with reckless aggression
  - Females: subtle seductive evil motives



## Borderline Defenses

- Splitting
  - intolerance of idea that caregivers can simultaneously be good and bad
- Primitive Denial
  - removing intolerable ideas or perceptions from consciousness
- Valuing and Devaluing
  - all good or all bad (but unlike splitting)

## Borderline Personality Response to Pain or Stress

- Impulsive
- Rageful
- Poor reality testing

## Conclusions

- Recognize discomfort in yourself
  - Make sure you have less pain than the patient
- Recognize patterns of dysfunctional interactions in your patients
- There are few absolute signs to identify the difficult patient
  - But there are usually multiple signs that absolutely indicate warning
    - These must precede your slowing down, taking inventory and carefully navigating the curves along your road