The nurse who worked the system

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Ms. Y has been hospitalized for suicidality 49 times in 6 years. Until now, her providers have condoned her sense of entitlement. How would you intervene?

CASE A 'high utilizer'

Ms. Y, a 49-year-old intensive care registered nurse, is admitted to the psychiatric hospital for suicidal ideation for the eighth time in 1 year. Ms. Y has chronic suicidal ideation with multiple attempts and has been on disability for 3 years for treatment of severe depression. She has been hospitalized for depression with suicide ideation 49 times since her divorce 6 years ago. She is prescribed fluoxetine, 60 mg/d, quetiapine, 400 mg/d, and clonazepam, 2 mg/d.

Ms. Y reports the same series of events that preceded her previous hospitalizations: severe insomnia led to a worsening of her other depressive symptoms, including intense suicidal ideation. In an attempt to sleep, she took "a couple" of extra clonazepam. She called her therapist, who was alarmed by her slurred speech and pleas for help. A friend drove Ms. Y to the hospital, where she was directly admitted without being evaluated in the emergency room (ER).

The authors' observations

Ms. Y possesses 7 of the 11 characteristics of a high utilizer of psychiatric services (***Table 1, page 70***),[1,2] defined as a patient who is:

- 2 standard deviations above the mean number of visits to an urban psychiatric emergency service in 6 months or
- has 4 inpatient admissions in a quarter or 6 inpatient admissions in 1 year.

Ms. Y always is directly admitted because she refuses to go through the ER for evaluation. She seems to know just how much medication to take to remain medically stable. She receives special treatment—she can call her therapist, ask for admission, and have her request granted. Until now, Ms. Y's care providers have condoned her entitlement.

What would be the next step to help this patient?

a) proceed with civil commitment because of her repeated suicidal gestures, hospitalizations, and deteriorating functioning
b) suggest an acute course of electroconvulsive therapy (ECT)
c) reconsider the patient's diagnosis and treatment plan
d) all of the above

The authors' observations

Because previous hospitalizations and courses of ECT have provided Ms. Y with only minimal, short-lived improvement, the treatment team decides to reconsider her diagnosis and treatment plan. Ms. Y's first psychiatrist diagnosed her with major depressive disorder. After thoroughly interviewing Ms. Y and reviewing her history,

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How would you handle this case?

Visit **CurrentPsychiatry**.com to input your answers and see how your colleagues responded

Clinical Point

Ms. Y receives special treatment, and until now her providers have condoned her entitlement

Table 1

Common characteristics of high utilizers* of psychiatric services

Homelessness
Developmental delays
Enrolled in a mental health plan
History of voluntary and involuntary hospitalization
Personality disorders
Likely to be uncooperative
Substance abuse or dependence (or history)
History of incarceration
Unreliable social support
Young Caucasian women

*Defined as having either 2 standard deviations above the mean number of visits to an urban psychiatric emergency service in 6 months or 4 inpatient admissions in a quarter or 6 inpatient admissions in 1 year

Source: References 1,2

the hospital psychiatrist determines that she meets criteria for borderline personality disorder (BPD) in addition to major depression. The psychiatrist explains this diagnosis to Ms. Y, provides her with education and support, and recommends dialectical behavioral therapy (DBT) and case management. She rejects the new diagnosis and treatment plan and pleads for help establishing treatment with a new psychiatrist.

The team at the psychiatric hospital feels Ms. Y needs to receive ongoing treatment from a psychiatrist. In the hope that she will be able to establish a therapeutic alliance with a new psychiatrist and therapist, they decide to continue working with Ms. Y if she accepts the BPD diagnosis and agrees to undergo DBT.

EVALUATION A troubling pattern

Before Ms. Y's husband divorced her, she had not received psychiatric care and had no psychiatric diagnosis. During the contentious divorce, she experienced depressive symptoms that later intensified, and she was unable to return to her previous high level of functioning.

Ms. Y became suicidal and was hospitalized

Table 2

Strategies for helping 4 types of 'hateful patients'

Dependent clinger	
Behaviors	Shows extreme gratitude with flattery
Associated personality traits/ disorders	Codependent
Management strategies	As early and as tactfully as possible, set firm limits on the patient's expectations for an intense doctor-patient relationship. Tell the patient that you have limits not only on knowledge and skill but also on time and stamina
Entitled demander	
Behaviors	Intimidates, devalues, induces guilt, may try to control with threats; terrified of abandonment
Associated personality traits/ disorders	Narcissistic, borderline personality disorder
Management strategies	Try to rechannel your patient's feelings of entitlement into a partnership that acknowledges his or her entitlement not to unrealistic demands but to good medical care. Help your patient stop directing anger at the healthcare team
Manipulative help-rejecter	
Behaviors	Resists treatment; may seem happy with treatment failures
Associated personality traits/ disorders	Psychopathy, paranoia, borderline personality disorder, negativistic, passive/aggressive
Management strategies	Diminish your patient's notion that losing the symptom or illness implies losing the doctor by 'sharing' your patient's pessimism. Tell your patient that treatment may not cure the illness. Schedule regular follow-up visits
Self-destructive denier	
Behaviors	Denial helps them survive
Associated personality traits/ disorders	Borderline personality disorder, histrionic, schizoid, schizotypal
Management strategies	Recognize that this type of patient can make clinicians wish the patient would die and that the chance of helping a self-destructive denier is minimal. Lower unrealistic expectations of delivering perfect care. Evaluate the patient for a treatable mental illness, such as depression, anxiety, etc.

Source: Reference 3

for the first time shortly after the divorce was finalized and her ex-husband remarried. She began treatment with a psychiatrist, whom she idealized and saw for 5 years.

When this psychiatrist—who had been one of the few stable relationships in Ms. Y's life—moved to another state, Ms. Y experienced a rapid recurrence of depression. She began treatment with 3 other psychiatrists but fired them because they "never understand me" like her first psychiatrist did, and she never felt she received the consistent, supportive care she deserved. She become suicidal and again required psychiatric hospitalization. This pattern continued up to her current admission.

The authors' observations

Ms. Y briefly returns to work between hospitalizations but is not able to tolerate the stress. At one point she was admitted to an out-of-state facility; after this 2-month stay, she remained out of the local psychiatric hospital for 6 months but then became

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The patient repeatedly takes more clonazepam than prescribed but adamantly justifies her actions

Table 3

Tips for managing high utilizers

Establish a collaborative treatment plan with firm limits and expectations

- Document the treatment plan and encourage the patient to actively contribute
- Provide the patient with a copy of the plan
- Have the patient sign release of information for other care providers and have active contact with them for continuity and accountability
- Specify that the patient can obtain prescriptions or have medication dosages changed only by a psychiatrist or primary care provider
- Document an emergency department treatment plan to prevent unnecessary medication changes, obtaining narcotics or benzodiazepines if the patient has chemical dependency issues, etc.
- Involve the patient's family

Acknowledge your feelings and countertransference

- Have regular contact with a mentor or colleague for consultation
- Ask yourself: Are you working harder than the patient? Is the patient capable of working harder or complying?
- Keep in mind the difference between mental illness and bad behavior

Explore your patient's expectations and commitment to treatment by asking:

- 'What do you consider as barriers to compliance or improvement?' (Share your thoughts with the patient)
- 'What are you willing to commit to in order to get better?'
- 'If I had a magic wand that I could wave and fix 1 thing in your life right now, what would it be?' or 'What is the number 1 area in your life that is causing distress?'

Practice safely and proactively

- Determine if the patient has an undiagnosed psychiatric disorder
- Provide a phone call reminder for appointments
- Call if the patient does not show up for an appointment
- Document, document, document

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High utilizers of psychiatric services are best helped by a treatment plan that establishes firm limits and expectations

unable to function and was readmitted to the local psychiatric hospital.

When interviewed, Ms. Y describes feeling hopeless, empty, and alone each time 2 of her 3 children return to college after summer break. Her youngest child lives at home but is involved in extracurricular high school activities, and doesn't seem to need her. Ms. Y is estranged from both parents. Her social support is unreliable because she tends to push others away and isolate herself.

Her children report that in recent months Ms. Y's functioning has deteriorated and they are frustrated with her. Ms. Y repeatedly takes more clonazepam than prescribed but adamantly justifies her actions, saying she takes extra doses to sleep or relax. She seems to "run to the hospital" each time she faces a challenge or has a responsibility to fulfill. Many of her hospitalizations coincided with special occasions, such as her children's birthdays, graduations, and holidays.

What would be the next logical step in Ms. Y's treatment?

a) have her work with both a new psychiatrist and therapist
b) schedule a care conference involving the patient, treatment providers, and family
c) suggest adult foster care
d) consider a diagnosis of bipolar affective disorder

The authors' observations

Because she has no history of mania, Ms. Y does not meet criteria for bipolar affective disorder. Her multidisciplinary treatment

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team feels she is too fragile to transfer care to new providers or to foster care, so we schedule a care conference and carefully compose a 6-month contract to formally articulate limits and boundaries within which we will continue to treat her.

The contract specifies that Ms. Y will participate in DBT, take her medications exactly as prescribed, and not receive any early refills of her prescriptions. We arrange with Ms. Y's health plan to have a home healthcare agency provide her medications weekly. This benefit was not available to other health plan members. Ms. Y signs the contract.

TREATMENT Contract violation

Ms. Y complies with the contract for 2 months, then abruptly fires her long-term therapist, whom she claims violated confidentiality by giving false information to another provider. At her next session, Ms. Y will not provide details about the alleged incident, and the issue never is resolved. She admits she did not start DBT and is not taking her medications as prescribed.

Ms. Y expresses her disagreement with the terms of the contract. She becomes very upset and asks for her care to be transferred to another psychiatrist. She demands to be followed at the current clinic because "I was born here." She denies being actively suicidal and terminates the session early. That afternoon, she calls 1 of the inpatient psychiatrists and asks if he would treat her. She also calls the first psychiatrist she had seen to enlist help in obtaining care.

The authors' observations

In Groves' description of 4 types of "hateful patients," Ms. Y represents a combination of an entitled demander and a manipulative help-rejecter. The behaviors and personality disorders associated with these types of patients—and effective management strategies—are listed in ***Table 2 (page 71)***.[3] ***Table 3 (page 72)*** offers tips for successfully dealing with high utilizers of psychiatric services. High utilizers of medical services other than psychiatry are more likely than patients who are not high utilizers to have a psychiatric disorder (***Box***).[4-9]

Ms. Y's entitlement interferes with her treatment—she has been allowed to dictate her treatment for years and, therefore, has not been managed effectively. She received resources that other patients did not, such as having weekly medication set up by a home healthcare nurse. Rules were bent to help Ms. Y, but allowing her to dictate treatment has made her so dependent that she worsened over time. Knowing that she was receiving special treatment appears to have strengthened her pathologic sense of entitlement.

Some members of our treatment team began to experience countertransference, which also interfered with Ms. Y's treatment. They viewed her behavior as entitled, demanding, and manipulative and dreaded caring for her. Failing to recognize such defenses can lead to consequences such as malignant alienation—a progressive deterioration in the patient's relationship with others that includes loss of sympathy and support from staff members—which can put a patient at high risk for suicide.[10]

continued

Box

'Hidden' psychiatric disorders lurk in high utilizers of medical services

Patients who are high utilizers of medical services other than psychiatry have up to 50% higher rates of psychiatric disorders—particularly depression—compared with less-frequent utilizers.[4-6] Screening medical patients for depression helps ensure that these patients are correctly diagnosed and treated.

Depression is a risk factor for nonadherence with medical treatment, and treating depression leads to decreased utilization of medical services.[7,8] Patients with successfully treated depression may have reduced functional disability as well.[9]

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Malignant alienation is a deterioration in a patient's relationship with others that includes loss of sympathy and support from staff

Clinical Point

The team terminated outpatient care for Ms. Y in part because the interventions provided had made her worse, not better

After a lengthy discussion among several psychiatrists, therapists, nurses, and attorneys, the treatment team decided to terminate outpatient care for Ms. Y at our facility because of her chronic nonadherence to treatment recommendations. Ms. Y had manipulated numerous providers in our department, called multiple doctors in our facility to ask them to care for her, and asked her ex-husband to contact the department administration on her behalf. Her behavior bordered on harassment. In addition, the interventions we provided were making her worse, not better. Factors that influenced our decision included:

- fear of Ms. Y committing suicide
- fear of setting limits
- fear of being reported to the Medical Board
- fear of a lawsuit.

The team sent Ms. Y a registered letter explaining the reasons for the termination and providing referrals for other providers in the area. She was told that she retains access to the ER and can receive inpatient psychiatric care, provided she first is evaluated in the ER.

OUTCOME The pattern continues

Ms. Y continues to receive treatment with a different outpatient psychiatrist and therapist in the area. She has not been hospitalized for almost 2 years but her financial state has deteriorated and she has had a recurrence of depression. Ms. Y's psychiatrist recently called the hospital to ask for direct admission on the patient's behalf, stating that Ms. Y did not want to wait hours to be seen in the ER. Hospital staff explained that she needs to first come to the ER for evaluation. Ms. Y refused to come to the ER and was not admitted. About 1 month later, Ms. Y's psychiatrist called again, and she was directly admitted to the psychiatric hospital.

Related Resource

- National Suicide Prevention Lifeline. 1-800-273-TALK (8255). www.suicidepreventionlifeline.org.

Drug Brand Names

Clonazepam • Klonopin
Fluoxetine • Prozac
Quetiapine • Seroquel

Disclosure

The authors report no financial relationship with any company whose products are mentioned in this article or manufacturers of competing products.

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Bottom Line

Psychiatric 'high utilizers' represent a minority of patients but consume a disproportionate amount of resources. A multidisciplinary approach that includes a well-developed treatment plan with early established boundaries and expectations is crucial. Be aware of countertransference and consult with colleagues frequently.