The Use of Ultimatums in Psychiatric Care

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One way in which psychiatrists deal with the problem of a patient who does not follow treatment recommendations is to issue an ultimatum, refusing treatment unless the patient abides by the doctor's treatment plan. The author examines a series of cases to outline seven general principles that can help the psychiatrist decide whether to use an ultimatum and to help make its use a thoughtful clinical intervention rather than an expression of exasperation. The guidelines address practical considerations, such as the complicating fact that ultimatums limit the psychiatrist's future responses to the patient, and ethical issues, such as the possible intrusion of the psychiatrist's self-interest or institutional pressures into treatment ultimatums.

The dilemma of what to do with a patient who is not cooperating with treatment recommendations comes up with sad regularity in psychiatric practice. If the patient is dangerous, the problem may be “solved” by involuntary commitment, a public act that has already received its fair share of scrutiny. Little attention has been given to an approach that, although usually much more private, is for the

I say [enter an alcohol treatment program, take this medicine, come to sessions regularly], or I will not work with you.” Only the language of ultimatums captures the unique power of this moment, which Corwin (6), in the specialized usage of psychoanalysis, has called a heroic confrontation.

An ultimatum can be very powerful indeed, but the particular nature of its power must be appreciated. Often it represents an abuse of power or a disregard of responsibility. Yet it may also be the only way out of meaningless or harmful treatment. The following principles can help a clinician decide whether to issue an ultimatum and distinguish between therapeutic and destructive uses.

An ultimatum controls the psychiatrist's future behavior and limits the range of responses to the patient. A resident came to me with a dilemma. He had been treating a chronic schizophrenic patient with a phenothiazine, and the patient's psychotic symptoms were clearly better. However, the patient was also an alcoholic who had been unmoved by pleas for sobriety from either his family or his doctors. The resident had recently told him, “Either you stop drinking and enter an alcohol treatment program, or I will stop seeing you.” Needless to say, the patient refused to comply, and the resident felt forced to make good on his threat. The resident then belatedly realized that although the patient would have been much better off not drinking, he was better off taking the phenothiazine than not taking it, even if he continued to drink.

The resident wished to write another phenothiazine prescription,
for the patient, but he discovered that the ultimatum now controlled the doctor as powerfully and as rigidly as it controlled the patient. Before issuing an ultimatum, a psychiatrist must decide if it is truly in the patient's interest if the doctor's future responses are limited and controlled by the terms of the ultimatum.

The case also illustrates another critical principle about treatment ultimatums.

When a patient has been unresponsive to interpersonal demands in the past, the patient may well force the psychiatrist to act on the ultimatum and end all treatment. Manic patients, like substance abusers, often force the issue. Not only are manic patients at times genuinely unable to respond to interpersonal maneuvers (7), but contingencies are simply not very compelling to them, as they already feel released from ordinary limitations.

A 38-year-old woman with bipolar disorder had a total of eight brief hospitalizations within one year. The usual pattern was for her to have a car accident while in a disorganized state, followed by involuntary hospitalization, partial recompensation, her adamant determination to leave the hospital, her enlistment of a lawyer's help, and premature discharge. Along the way, she fired any psychiatrist who opposed her wishes for outpatient treatment, "exploratory" psychotherapy, and the medications of her choice.

A patient whose behavior is historically unresponsive to interpersonal threats or expectations is not likely to respond differently to a psychiatrist's threat. Nine times out of ten, a clinician who issues an ultimatum will be forced to terminate treatment. Ironically, the patients who most invite an ultimatum are the ones who are least likely to be responsive to one. This fact leads to the next principle.

The critical question when a patient offers partial cooperation is whether full cooperation would benefit the patient more, but whether ending all treatment would be a significant loss to the patient. The question to ask before deciding to impose a contingency on continuing treatment is not the physician's usual question, which is whether the patient would be better off with the prescribed treatment than with some other arrangement. The critical question is whether treatment on the patient's terms is in fact harmful or simply so ineffectual that it would not be a significant loss if the patient ends up, as is likely, with no treatment at all.

When a patient refuses some but not all of a recommended treatment plan, one must ask if the treatment that is refused is necessary for the efficacy of the treatment that is accepted. Put in the language of contingencies, if the efficacy of the first treatment is not contingent on the patient's also receiving the second treatment, we do not have the right to make our offer of the first contingency on the patient's also accepting the second. When patients have somewhat separable problems, we owe it to them to make clear all that we think is wrong and what treatments we think would be most helpful, but they must have the right to accept our help with some of their problems while denying our wish to fix everything about them.

For the patient with both chronic schizophrenia and alcoholism, the ultimatum was an unfortunate application of the belief that in the presence of untreated substance abuse, no meaningful psychiatric care can be given. Because the resident recognized that this dictum was not valid for his patient, he resumed treatment with the antipsychotic and sought other ways to interest his patient in alcoholism treatment. However, the case of the manic woman involved in recurring car accidents raises additional questions about the use of ultimatums, which is the next principle addresses.

A psychiatrist's self-interest may easily intrude into decisions about treatment ultimatums. The best safeguard is to make such decisions in the view of one's peers. For the woman with mania, the overwhelmingly evident evidence from the repeating sequence of premature discharge, car accident, and rehospitalization is that the patient needed to remain in the hospital until she was euthymic to break out of a destructive cycle that was endangering both her and others. Yet rather than being faced with an ultimatum, she found a series of psychiatrists ready to support her discharge and to treat her as an outpatient.

Part of the problem may have been that some manic patients can appear completely lucid during a single interview. However, much of the problem seems to have been economic. Case records describe the patient as a very successful businesswoman with a six-figure income. One psychiatrist who agreed to treat her as an outpatient frankly admitted that he hoped she might be a good referral source. Another agreed to see her in consultation for an unusually high fee.

While it is tempting to moralize here, the simple fact is that one way to get people to do harder work is to pay them more. Sometimes psychiatrists take on difficult patients out of interest or compassion, and sometimes they do so for the money. The real concern is that economic factors can distort clinical judgment by diverting us from therapeutic honesty and necessary confrontations—for example, from telling a patient that she should remain in the hospital. The best safeguard is to be involved with colleagues in a way that opens our work to their view, where our judgment and our motives can be called into question constructively; a peer supervision group is one such forum for those whose jobs do not provide other opportunities.

Self-interest is of course just as likely to trigger an ultimatum as to discourage one. The patient who was manic fired her first psychiatrist but continued to call him frequently, sought further appointments, was demanding and devaluing on the telephone, and threatened to sue him. He finally told her he would get a restraining order if she continued to harass him.

Here it is more difficult to avoid moralizing. A psychiatrist is not relieved of all professional obligation simply because a patient, in the midst of a psychosis, has fired him. If there is a question of safety, he still has the power to arrange for hospitalization rather than to abandon the patient. Termination addresses only the psychiatrist's problems, not the
patient's treatment needs. However, the threat of a suit, even when it is the result of mental illness, certainly is not grounds for commitment. Nevertheless, a restraining order is a troubling alternative. It is the response of one citizen to another, not the response of a doctor to a sick patient.

However, when things are going badly with a patient, one response is always available within our professional role. The clinician can obtain a consultation from a trusted colleague, in hopes that it can promote a more effective alliance with the patient.

Do not neglect the potential gain in therapeutic alliance that comes from trusting the patient unless the trust is proven to be misplaced. Walker Percy (8) attributes the following statement to Harry Stack Sullivan: "Here's the peculiar thing and I'll never understand why this is so: Each patient this side of psychosis, and even some psychotics, has the means of obtaining what he needs, she needs, with a little help from you."

The passage implies a need to listen very carefully to what each patient has to say about his needs. But, keeping in mind Sullivan's concept of the psychiatrist as expert (9), it also implies that sometimes we see what a patient needs better than the patient can. The proper balance between faith in what patients tell us and trust in our own understanding is hard to achieve (10), especially since both flexibility and rigidity about imposing contingencies can, at different times and with different patients, do serious damage.

When I was in charge of an inpatient unit, one patient on the unit had a remarkable ability to generate hatred from staff and other patients. Before discharge she eloped from the unit. While patients and staff were pleading with me not to allow her to come back, she began a series of phone calls to me to negotiate the terms of her return. During this time she resumed seeing her hospital therapist as an outpatient. The therapist agreed to continue to treat her and would not interfere in any way to get her back to the hospital.

I thought the therapist was making a serious mistake by offering the patient a treatment that had no chance of success and, in the process, diminishing the likelihood that the patient would return to the hospital, where she clearly needed to be. In one sense I was right, because the therapist had to commit the patient to the hospital a month later, but I now realize that the therapist clearly did what was best for this very difficult and distrustful patient. The therapist's willingness to try to work on the patient's own terms established a bond between them that permitted them to work together, when the patient finally returned to the hospital, in a way that could not have been possible otherwise.

Many psychotherapy outcome studies show a high correlation between outcome and patient ratings of therapist empathy (11). It may be that we gain something simply by our willingness, at least initially, to try treatment on the patient's terms, to trust the patient's view of what he or she needs, before insisting that we have a better understanding of it.

Be wary of institutional pressures to trust conventional wisdom over the patient's understanding of his own needs. Of course, empathy for a patient's needs is not equivalent to softheartedness. When I was new to psychiatry, one of my patients needed to leave the hospital because her insurance benefits were exhausted. She was still actively psychotic and so disorganized that inpatient treatment was clearly optimal, but she had two young children and no husband at home. She was determined to return home to care for her children rather than transfer to a state hospital. I thought that her goal was worthy enough for me to find some way to make it possible and still provide for the safety of her children, who in the past had been endangered by her behavior.

I told the patient that I would discharge her to an outpatient program if another adult were involved in her children's care. She proposed that they all live with her sister-in-law, adding that her sister-in-law could not leave work during the week to meet with me and was also afraid to come on the grounds of a mental hospital. I finally accepted the offer of a Saturday morning meeting with the sister-in-law in a nearby ice cream parlor, where we agreed on a discharge plan. After the patient was discharged, I learned that she and her sister-in-law had never intended to abide by our agreement and that the patient was living alone with her children. I felt that I had no choice but to file the state's mandatory report of child abuse or neglect.

As in the preceding case, I had made an error in judgment. Significantly, I was more embarrassed about being too flexible and doing business in an ice cream parlor than I was about being too rigid in demanding that a therapist force a patient back into the hospital. Because institutional life is inherently conservative, greater embarrassment about flexibility than about rigidity is a characteristic of those who function within an institution.

The risk that we take with our professional reputation in listening to patients' ideas about their treatment needs is greater than the risk that we take in disregarding their ideas for the sake of conventional wisdom. Some of the patients described here were clearly mistaken in their assessment of their needs, but the systematic institutional pressure on us does not always work to the benefit to our patients.

As the word implies, an ultimatum is an intervention of last resort. An ultimatum is a poor alternative to an understanding between doctor and patient. Empathy with the patient's predicament, education of the patient about the reasons for the treatment plan, and a sincere effort to understand and to address the patient's objections to the plan are the best paths to a shared understanding. When those paths fail, a consultation can often help us to ally ourselves more effectively with the patient. But at times a shared understanding is genuinely out of reach, and an ultimatum is the only way out of a treatment impasse.

References
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