Patients with Borderline Personality Disorder who are Chronically Suicidal: Therapeutic Alliance and Therapeutic Limits

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Therapeutic work with patients who are chronically suicidal and have borderline personality disorder (BPD) is challenging, and clinicians often resort to setting firm limits or excessively cautious interventions in efforts to prevent manipulation, regression, or over-dependence. Litigation and malpractice fears reinforce these stances, and reduced compensation for additional time and energy devoted to patients adds further disincentives to sole providers. However, elements of the working alliance and therapeutic limits are within the therapist's control. A case vignette illustrates an individual therapist's modification of usual therapeutic limits while working with a chronically suicidal patient with BPD within a dialectical behavior therapy (DBT) framework over a 16-week period. Discussions regarding the case, interventions used, DBT, and legality concerns follow.

KEYWORDS: Borderline Personality Disorder; suicide; phone coaching; therapeutic alliance

INTRODUCTION

Clinicians are often warned about therapeutic work with patients who have personality disorders, particularly patients who are chronically suicidal and have borderline personality disorder (BPD). We are cautioned that certain boundaries and clear parameters must be established in order to prevent calamity. This may include "setting clear limits," such as adhering to strict payment and scheduling policies or practicing complete lack of personal disclosure. These measures provide unwavering and consistent messages to patients, limiting interaction to time-limited and focused intervals to prevent regression and overdependence. Litigation

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and malpractice are additional real-world fears reinforcing these stances. Furthermore, therapists face pressures from third-party payers and are awarded reduced, if any, compensation for additional time devoted to patients. These variables—complex psychopathology, poor reimbursement, and a legal culture of caution—support the splintering of services and prevent sole providers from engaging in comprehensive care of chronically suicidal BPD patients. As such, it seems the days are dwindling for therapists in private practice to single-handedly manage patients who repeatedly self-injure and wish for death.

This shift seems inevitable as standards of care change; interdisciplinary approaches, including dialectical behavior therapy (DBT), are increasingly popular. However, the manner in which individual therapists approach such complex patients remains relevant as DBT and other multipronged approaches may not be readily available to certain patients or in particular regions. The following case vignette illustrates an individual therapist's modification of usual therapeutic limits within a DBT framework while working with a chronically suicidal BPD patient. Discussion regarding the case and interventions follows.

CLINICAL VIGNETTE

Mrs. A[1] was in her late 30s, residing in a suburban home with her husband (of nearly 20 years) and three children. At the time of treatment, she was employed full time in a healthcare setting. She was voluntarily admitted to an inpatient psychiatric unit after an overdose of 69 tablets of her antihypertensive (hydrochlorothiazide) medication. According to Mrs. A, this ingestion was intended to end her life and it had occurred within the context of her upcoming birthday and her husband's attempt to leave her. Her admission was facilitated by a mobile outreach team that she called one day after she ingested the pills; when she realized she did not die, she feared she may have caused irreversible organ damage. There were no medical consequences to the ingestion and she was cleared for psychiatric evaluation.

During initial evaluations Mrs. A was described as cooperative but guarded and less than elaborative. History revealed that for several months she had experienced low mood, poor energy, impaired sleep, feelings of hopelessness and helplessness, social withdrawal, irritability, and multiple instances of suicidal ideation, with plans and intent to overdose on medication. She described being "tired of life," and often hoped she would

[1] NOTE: The patient's identity was disguised sufficiently for confidentiality purposes.

not wake from sleep. She had never thought of herself as experiencing depression, but after the suicide attempt and inpatient treatment she considered this diagnosis as "likely."

Mrs. A reported her suicide attempt was made "out of spite" because of "some things my husband said." She did not leave a note or tell anyone about her plans; she ingested the tablets impulsively in the absence of witnesses and only later notified the mobile crisis team. She demonstrated little if any insight into her personal role in the act. She attributed the cause of the suicide attempt to external factors, such as her husband's comments and others withdrawing from her or letting her down.

Mrs. A reported a very similar overdose the year before and denied requiring medical attention, stating that "nobody even noticed." She reported multiple suicide attempts (mostly overdoses) and three inpatient psychiatric admissions from ages 13 to 19 years old, during which she experienced ongoing sexual and physical trauma. At least twice during this adolescent period she was briefly arrested for domestic disputes with her then partner; once she allegedly pulled a gun on him and on another instance bit him, but charges were dropped in each case. She consistently refused to describe her earlier suicide attempts, psychiatric treatment, violence, or trauma in further detail. She also refused to discuss her upbringing, only noting that her mother was addicted to illegal substances and was less than present in Mrs. A's life. She denied any history of self-injurious behavior, such as cutting or burning, noting that she was always "scared of pain." She also denied manic, obsessive-compulsive, panic, phobic, paranoid, perceptual, or otherwise psychotic symptoms. She similarly denied substance abuse, disordered eating behaviors, or otherwise impulsive behavior aside from the aforementioned interpersonal aggression during her teens.

Mrs. A's social circle was primarily composed of her husband, an incarcerated younger brother with whom she felt close, and one best friend. Both of her parents were deceased, and she did not feel particularly close to her two siblings. Medically, her hypertension was well controlled with hydrochlorothiazide, which had been prescribed by her primary care clinician. She had no other significant medical or surgical history.

Despite appearing guarded during most interactions, Mrs. A described feeling motivated towards recovery; the inpatient psychiatric team referred her to the women's intensive outpatient program (WIOP) with the goal of reducing suicidal behavior and ideation while developing alternative coping mechanisms. Treatment in the WIOP was based largely on principles of dialectical behavioral therapy (DBT) and was multifaceted, including

attendance at three-times-a-week skills groups, weekly medication management with a psychiatrist, weekly individual counseling with a therapist, and ongoing telephone coaching with said therapist.

TREATMENT

As a fourth-year psychiatry resident rotating in the WIOP, I was assigned Mrs. A as my therapy patient. Mrs. A. was advised that as part of her treatment planning, she would call be called away from one of her thrice-weekly group sessions for individual counseling with a therapist. She was typically seen for approximately 35 to 45 minutes in an adjacent office before being returned to group.

During our first session, Mrs. A appeared as guarded and evasive as she had been described in inpatient evaluations; at first I opted to remain superficial by discussing group treatment. It was evident that in order for her to divulge aspects of herself she would require nonthreatening, validating statements communicating interest and curiosity. She reported that she felt the groups were not helpful but was motivated to reassess their utility. When asked about her moods, she reported feeling and functioning well, noting that she "should be fine for the time being due to all of the attention" she had received after her suicide attempt. She noted, however, this attention would be temporary and she was not optimistic that she would "remain novel" to others, including her husband, family, and treatment providers. She evaded discussion of her interpersonal difficulties with husband when asked, but agreed to discuss the dynamic at a later point.

We briefly touched upon her chronic suicidal ideations and her desire to simply not exist; she genuinely regretted not succeeding with her latest suicide attempt. She appeared somewhat scripted in her conversation when she quickly declared feeling "hopeful" and compared her treatment in the WIOP groups to Alcoholics' Anonymous groups, with her suicidal ideation replacing substances as the "addiction." Mrs. A also shared that she had difficulty asking for help or assistance from others because she did not want to burden others. She noted this was her interpersonal style since adolescence. She contrasted herself to her younger brother, who she described as her polar opposite and who relied upon others without hesitation. We linked this revelation to the interpersonal effectiveness module of the DBT skills group and discussed the difficulties people face both in asking for help and in refusing requests. This led to a discussion of the use of help within this very therapy, specifically phone coaching. Though I had never provided even e-mail access to my previous patients, she was given my direct cellular phone number and encouraged to call in

the event of crises. I clarified that I could only be effective in problem-solving crises with her before she tried less-than-adaptive coping strategies (i.e. impulsive suicide attempts). She accepted this resource, expressing reluctance to use other avenues, such as mobile crisis teams or hotlines. In addition, due to Mrs. A's difficulty initiating outreach and a pattern of allowing stressors to accumulate to a point of inevitable crisis, she was asked to call me twice a week (Monday and Friday) at a scheduled time. She agreed to these noncontingent calls, which were recommended by the larger treatment team.

Mrs. A denied any suicidal intent or plan at that time and felt safe. As with many future sessions, a comprehensive safety assessment was done, reviewing access to any potentially lethal devices, with a special attention given to medications. Her husband was charged with holding her antihypertensive medications, and she denied access to any other methods or weapons.

Prior to our second in-person session, Mrs. A missed both scheduled calls, prompting me to call her on each occasion. During the first of these calls we briefly chatted about her weekend plans; she did not answer the second call. She also missed group that day, but contacted the group leader indicating she had overslept because of a headache. Mrs. A was in bright spirits for our second session. She endorsed mild anxiety and restlessness over the previous few days, with increased activity (errands, outings, cleaning) as observed by others but no impulsive behavior, pressured speech, sleeplessness, or grandiosity. She felt this was similar to other suspected hypomanic episodes that she had, until now, not shared with providers, but planned to discuss with the psychiatrist that week. She described some anger issues from the past weekend, specifically provoking her husband into arguments and then regretting it. She noted he was being "extra supportive and affectionate," to a degree she found artificial and even annoying. She felt his concern would prove only temporary and remained cautious that in weeks to come it would wane. This feeling led to a brief discussion about prevention of any emotional fallout, but she considered herself ill-prepared to anticipate mood states or the accumulation of stressors.

Mrs. A also noted ongoing suicidal thoughts, periodically thinking about different options she might have in terms of ingesting medications, which included over-the-counter agents. She denied any actual intent or plan, but noted that she spontaneously conjured images of overdosing, and wished this were not the case but found it beyond her control. We discussed how the majority of her life she entertained suicide as an escape

from daily, personal hardships; we further linked this to her highly negative and disillusioned perspective on life, the world, and the future, which stemmed from past traumatic experiences. We did not explore the content of these traumas (and never would), but she agreed they were formative in her generally bleak attitude toward existence.

We discussed possible impediments to her phone coaching calls. Mrs. A lumped all mental health care practitioners—the inpatient psychiatric unit, the mobile crisis unit, and the WIOP team (including me)—into a group of clinicians who would reflexively hospitalize her if she openly shared her thoughts. I reassured her that we considered safety very seriously, but we also held high thresholds for hospitalization for suicidal ideation and depressive symptoms. She was also informed that silence and lack of communication was often interpreted by clinicians as a sign of severe illness, and that clinician concern or hospitalization would be more likely in this scenario rather than in one in which she shared her feelings.

Before our next session, Mrs. A and I had our scheduled call, discussing briefly her plans for the week and some difficulties experienced over the weekend not only with suicidal thoughts but also with use of distraction and other coping mechanisms.

Surprisingly, I received an unscheduled call from Mrs. A one workday; she was forced to leave a message as I was with a client. In it she described having experienced an unprovoked "panic attack" lasting 20 minutes or so. Upon returning her call, she explained that she had found relief by calling her husband who was able to calm her.

Our third session featured praise for Mrs. A's skillful use of both her husband and me during an emotional crisis; she herself recognized these acts as reasons to feel hopeful for recovery. We closed the session discussing her tendency to view things negatively and hopelessly, with a recent departure in terms of considering a more hopeful and positive perspective. Intellectually, Mrs. A considered suicide a poor option and I encouraged her to consider what sort of a life, no matter how distant from her current predicament, she would find worthy of crafting and living.

Mrs. A continued her noncontingent calls, not only discussing her improved mood and outlook but also her ongoing struggles with motivation and ability to leave her room. In session, she appeared in bright spirits, expressing anticipation of further improvement. Mrs. A denied suicidal or lethal propensities; nonetheless, she felt emotional instability as a result of "dealing" with thoughts and feelings rather than suppressing them. I encouraged her to think of this form of introspection as an anxiety-inducing departure from her usual state. This change was also viewed as an

unusual expenditure of mental energy, forcing her to stay home. We discussed potential behavioral activation techniques, such as scheduling regular walks and activities, but she considered this approach dubiously. We reiterated how skillful she had been in asking for assistance and in making noncontingent calls, and she once again recognized progress without feeling stupid or weak.

The following week proved to be a setback in Mrs. A's progress. She did not call on Monday as scheduled, nor did she respond to a call back. Two days later she reported to the group session leader that she had ingested her antihypertensive medications on Monday; upon hearing this, the treatment team decided sufficient time had elapsed from the ingestion to warrant a physical assessment in a nonurgent setting, and Mrs. A was advised to contact her primary care clinician for follow up.

Although Mrs. A confirmed having arranged such an appointment very quickly, she ultimately did not go. She then missed the Friday group meeting, prompting a telephone call from me to assess her status. Mrs. A explained to me that she could not come in because her daughter was ill; she added that she missed the appointment with her primary care doctor because she was at court combating a parking violation. In this phone exchange I informed her that the treatment team was worried about her and if she did not attend the session scheduled for that day, other measures, such as the mobile crisis team, would be utilized to ensure her safety.

This motivated Mrs. A to come in for treatment. She explained she was concerned that reporting her ingestion would legally bind me to commit her for psychiatric hospitalization. She was informed that this was not necessarily the case, and that the likelihood of having her involuntarily committed was very low for number of reasons, among which were: the expectation that she would have set-backs during the course of treatment, the inherent lack of benefit to a psychiatric hospitalization at that point, and that I did not "enjoy" committing patients. She was relieved by this explanation but remained skeptical and guarded.

Mrs. A was then invited to think about how her lack of communication might be perceived by the treatment team (more specifically myself). She did not seem insightful about the impact of her silence. We discussed the actual ingestion of the medication, which, she revealed, had been limited to eight tablets of hydrochlorothiazide; Mrs. A stopped herself after the eighth pill because she noticed she was "going down the wrong road." While I praised her for effectively stopping herself in the middle of the destructive behavior, I encouraged her to see how ineffective she was in

using treatment resources immediately before and after the behavior (DBT argues that the patient needs to utilize skills before and after an incident). We processed Mrs. A's feelings of shame and inadequacy related to her perceived failure in seeking help. After consultation with a toxicology service regarding the ingestion, the treatment team felt comfortable foregoing Mrs. A's medical evaluation.

Later that day Mrs. A called during a moment of crisis regarding new evidence of her husband's infidelity. She used me as a resource, asking for help in controlling her emotions of anger and frustration. She admitted to suicidal urges, but was able to think of alternative strategies (such as distraction) to get through the weekend. It was suggested she not confront her husband in the midst of a heightened mood state, but instead consider what DBT proposes as "radical acceptance" of his behavior and not allow it to dictate her emotional reactions. She appreciated this perspective.

In the following session, Mrs. A updated the situation with her husband: several days after we spoke she indeed discussed his infidelity with him but to her surprise experienced no overtly negative emotions. She took this as evidence of her potential to improve. We also explored how she felt about us in our therapeutic relationship, and she confirmed that she now trusted me more fully to not commit her or to overreact to suicidal fantasies. We spoke about longstanding difficulties with trust; we predicted that although she found me trustworthy then, this trust would diminish with time given her history. Indeed, when informed of my upcoming two-week vacation within the same session, a visible change in affect ensued. Mrs. A described feeling "stupid" because she had not anticipated the impermanence of our therapeutic relationship. I reassured her I would remain available for the duration of her time-limited WIOP treatment, but that she would also benefit from an individual therapist after WIOP. I cited her rapid attachment to me as evidence of her capacity to work closely with a trustworthy provider.

After the vacation announcement, Mrs. A missed two consecutive group sessions, but reluctantly showed for the third of that week; she was asked if during my absence she could contact someone from the treatment team as she regularly did with me. Although she denied any suicidal intent, she explained that she trusted only me and felt others might commit or punish her for any openly suicidal expressions. She assured her attendance at groups and assured she would telephone if she missed a group, but could not commit to further engagement. At this point I encouraged her to begin to imagine a life outside of our therapy, and once again invited her to envision working closely with another therapist who would tolerate her

suicidal proclivities while not condoning them. She agreed with this, and voiced that though she was upset regarding my upcoming absence, she felt it could be a challenging time for her to implement skills learned from group and to test her self-reliance.

Mrs. A was seen individually and in group by other members of the WIOP team during my absence. Upon my return, she described her mood over the preceding two weeks as "up and down" and her days as "a battle." She added that she actually maintained twice-weekly phone checks with another therapist at our regularly-scheduled times but hoped to resume these calls with me. Mrs. A denied any recent self-injurious behavior or suicide attempts, but noted ongoing, periodic urges to disappear or not to live. She described her ability not to act on these impulses as a feat and was impressed with herself; she could not name any particular skills employed in this. Mrs. A also found it difficult to list reasons why she continued to choose to live; although she cited her children as reasons for life, she quickly corrected herself, stating that "honestly, nothing is keeping me alive other than hearing all these people tell me I can get better." She was once again encouraged to conjure an existence or predicament worth living for, even if far-fetched or unobtainable at the moment. Although she reacted with some anger to this, she agreed to explore the notion. Mrs. A also shared recent accomplishments in her interpersonal life, such as actively requesting her brother not to ask her for money or favors as he used to as and asserting to her husband her need for an active and social existence with frequent outings and exposure to others.

Phone contact with Mrs. A continued over the following week, including noncontingent calls and a Sunday night call. Her frustration and anxiety regarding her family members increased; more specifically, her husband had discussed the possibility of imminently leaving her, and her teenage son was increasingly defiant and difficult. During our phone exchange we again discussed her need not to dictate her behavioral responses according to others' actions. She agreed and once again conceptualized this as a form of radical acceptance.

In order to not miss group and to be away from her husband, Mrs. A slept in her car the night before the next session. She reported that she had given her husband an ultimatum: either be fully committed in matrimony or leave. She felt that he was very invalidating when he would brush her off, and he would not say which of the two situations he would investigate. We explored possible reasons for her husband wanting to leave her, recognizing his ambivalence to commitment to her and comparing this with her ambivalence towards living. Mrs. A recognized his insecurities,

and she was hopeful about attending couples counseling in the future because her husband had in the past said he would attend sessions.

Mrs. A failed to call as scheduled on the Monday preceding our next session, and I left a message informing her that if I didn't hear from her, I would be forced to recruit the mobile crisis team to assess her. She did not call back and the team was recruited, but when they visited her home no one was present. Mrs. A appeared at group two days later and explained that she had been upset since Monday's group, and because she did not feel safe at home spent the following two days drinking with a relative. She denied impulsive or reckless activity while intoxicated, and she denied suicidal plans or intents. On further reflection, however, Mrs. A offered passive death wishes by alcohol consumption. She added that she did not call me because she "didn't feel like it." This led to an explanation of our heightened concerns as a treatment team when we did not hear from her. She understood, but she did not promise she would be able to call if she were in distress. Despite this, Mrs. A was asked for an alternate phone number, and I encouraged her to resume our previous twice-weekly phone arrangements. Feeling particularly frustrated and enraged at my own efforts to work with Mrs. A, I concluded the session by walking out before her, cautioning under my breath that she should remember she was still "commitment material."

This threatening (and somewhat punitive) manifestation of my anger was processed in the weekly treatment team meeting; instead of identifying Mrs. A's escape to her relatives' home as a relatively adaptive alternative to her usual, overtly suicidal and isolative tendencies, I had fixated on her noncompliance with treatment and phone contact. It was important for me, a novice therapist, to identify how my anger had been informed by a sense of therapeutic helplessness. In the meantime, Mrs. A failed to attend groups or return calls for several days, and the mobile crisis team was once again dispatched to assess her safety. On this occasion she was indeed evaluated, found to be safe, and encouraged to return to treatment.

A nuanced response to the fallout and repeated use of the mobile crisis team was crafted with the assistance of the team members: I contacted Mrs. A by telephone both to praise her for having avoided overt suicidal behavior as well as to inform her of my willingness to continue to work with her despite recent frustrations. In addition, she was invited to see my anger as evidence of my own emotional investment in her well-being and my frustration as, not with her, but with the inherent difficulties of treatment and her illness.

Mrs. A responded well to this, resuming calling as originally scheduled;

she was rather guarded at first, but confirmed her safety. We spoke very frankly about my frustration because she felt uncomfortable and anxious immediately afterwards. She shared various cognitive distortions about that meeting, explaining that she thought I didn't want to work with her and that I disliked her. We distinguished these expected and even understandable thoughts and feelings from the unjustified avoidance behaviors that might result from them. We also spoke at length about her general avoidance pattern, identifying feelings of shame, anxiety, insecurity, and inadequacy and noting her general concern of "being judged by others." These concerns received overdue and authentic validation in the context of the experience between us (as opposed to those with others outside of the therapy) and solidified our future work together.

In our next face-to-face session (the first since my overtly angry response), Mrs. A presented as withdrawn, evasive, and superficial, indicating she was simply "fine." For the first time since beginning treatment she voiced a desire to return to work, feeling it would provide meaningful activity. Her schedule of remaining treatment was broached, and I suggested that after we terminated sessions she continue follow-up with another a provider. She shook her head and explained she would rather not speak to anyone. She became tearful in describing how difficult and painful the treatment process had been in terms of constant awareness of feelings and emotions, including her chronic suicidal ideation. Mrs. A felt she gave this "method" of introspection "a good shot" but would much rather remain avoidant and in denial. She recognized her periodic tendency to abruptly express emotions that had been "bottled up" or suppressed, but argued she would nonetheless prefer to "deal with them then." She seriously doubted her ability to employ skills taught in the group during those events, noting her ability would "depend" on the severity of the stressor.

We shifted discussion to Mrs. A's inability to observe her emotions and anticipate their escalations; she felt this inability denoted weakness and was itself shameful and unacceptable, once again prompting avoidance. Given her refusal to work with a therapist, she was encouraged to consider the role of medications and periodic evaluations with a psychiatrist with the goal of reducing the severity and frequency of suicidal feelings. She was reminded that medications would not address underlying conflicts but rather assist in their suppression. Not surprisingly, she communicated less opposition to medications than to psychotherapy.

Mrs. A continued to call as scheduled; in these communications she often spoke about managing emotions with the use of group-derived DBT

skills, such as distraction, radical acceptance, and opposite-action. She shared how a recent episode of panic surprisingly lacked suicidal urges and actually improved with her husband's presence. She felt her husband had been more engaged and attuned to her needs, but warned that "this could all change," and that she was always "waiting for the other shoe to drop." In another noncontingent call, Mrs. A expressed an unspecific "stress" but denied active lethality to self: she responded well to reassurance and validation, as well as an invitation to call me as needed.

During our next in-person session, she became visibly anxious when discussing her use of me as a phone resource, noting that she felt shame about her dependence on a constantly available therapist and regret about having "started this process" if it required imminent conclusion. She also voiced how simply knowing that I was available had been very helpful, but she expressed opposition to starting a new therapeutic relationship ("its too painful") when informed how unlikely this open and direct arrangement would be with future therapists. She also viewed my leaving (my residency was drawing to a conclusion) as "an abandonment;" I silently acknowledged this and encouraged Mrs. A to identify any potential benefits of this therapeutic trial, despite its uncomfortable end. Although she expressed difficulty with this suggestion, she ultimately noted that it kept her alive "for a few months." She could not anticipate benefit from future therapies.

Mrs. A was informed by the group leader that my availability as a therapist was limited as I completed residency in coming weeks and that her group treatment was independently nearing completion. Mrs. A requested a tapering off of treatment and was scheduled for a few sessions, but ceased scheduled calls. I opted to allow her space and time, instead of calling to assess her safety, so that she could privately process our upcoming termination. During our final session, Mrs. A presented uncomfortably and evasively; in discussing the end of therapy, however, she assertively described it as "shocking" and sudden. She noted feeling anger at my leaving, but explained that she had processed it at home and accepted the change "radically." I informed her (perhaps defensively) that not only had her treatment actually lasted longer than usual, but also that my involvement with her was beyond the conventional therapeutic limits. She thoroughly appreciated this and recognized it as a sign of our treatment being "personal" and by extension, "life-saving." Mrs. A was reminded (again, defensively) that though the treatment certainly contained personal elements, it was not particular to me as a person or therapist, and I reassured her that she would be able to find good,

balanced, personalized support in a future provider. She had indicated acceptance of the notion after "thinking about it a lot" and communicated intent to see a second therapist.

Throughout this final session, Mrs. A thanked me numerous times, becoming tearful and demonstrating the most genuine affect to date. She compared my nonjudgmental, validating stance to that of her husband's in earlier stages of their relationship. She also noted real growth from having experienced and tolerated me as a "real person," who she initially had idealized but later recognized as possessing both good and bad components (she explicitly cited the instance of my overt frustration). Without prompting from me, she likened this ability to tolerate as a new learning experience, vividly comparing it to that of "a baby learning to walk." I thanked her as well for the pleasure of being able to work with her.

Mrs. A was in treatment with the WIOP and me for a total of 16 weeks. It should be noted that, due to her degree of guardedness, Mrs. A's only psychopharmacologic treatment during this time was low-dose sertraline (antidepressant), which had little, if any, discernible effect. [Please delete the line below, thanks!]

COMMENTARY

In the case above Mrs. A presented with ongoing emotional instability and chronic, suicidal behavior. This was fueled largely by a history of trauma, informing a particularly bleak and negativistic outlook on life. Her defensive structure was notably guarded and skeptical, and her interpersonal style reflected this as she experienced others as intrusive. A false veneer of control and self-reliance appeared to prevent others from helping her in the manner she needed most; this, in DBT parlance, is characterized as "apparent competence." Self-identification with feelings of inadequacy, shame, and helplessness were nonetheless revealed with sufficient exploration. A constellation of such interpersonal difficulties, affective dysregulation, somewhat paranoid and overly-guarded disposition, mentalization and other ego deficits, diffuse identity, impulsive behavior, and chronic suicidal tendencies strongly suggest a diagnosis of Borderline Personality Disorder.

A focused, time-limited, multifaceted, DBT-informed approach to the chronically suicidal patient with BPD was illustrated here. The overall philosophy of this treatment model is quintessentially behavioral, characterized by clear problem behaviors, well-defined goals, an arsenal of teachable skills, close scrutiny of antecedents, and both positive and negative reinforcements. In terms of individual work, DBT instructs that

therapists be simultaneously validating and confrontational with their chronically suicidal BPD patients; hence the dialectical of balancing opposite forces of change and acceptance (Linehan, 1993). Ultimately, however, much of the individual work is, by nature, less formulaic or standardized than skills group work. Such individual work may more closely approximate psychoanalytically informed psychotherapy, alternating supportive and expressive interventions and featuring affective processing in a manner particular to the patient. As such, treatment in the above case blends behavioral and psychodynamic mechanisms of action.

Although punctuated by behavioral disruptions and minor setbacks the approach appears to have been successful in terms of reducing the intended behavior (i.e. suicide attempts) as well as in arming the patient with alternative coping mechanisms (i.e. distraction, radical acceptance, interpersonal effectiveness, asking for help, etc). In addition, individual work with the therapist both in person and via telephone helped strengthen the patient's ability to observe herself, tolerate ambiguity, accept both negative and positive aspects of those around her, develop hope, counter pessimism, confront uncomfortable feelings including shame and dependency, and improve interpersonal negotiation. Although each of these gains was met with considerable resistance and skepticism, including a general preference against awareness altogether, the patient's use of the therapist in times of real crisis, her use of newly learned coping mechanisms, her significant attachment to the therapist, and her affectively authentic descriptions of developmental progress collectively speak towards genuine growth.

It should be emphasized that any gains the patient made occurred as a result of a multipronged approach, with various providers (psychiatrist, therapist, skills group) and variables (external motivation, fear of hospitalization). The clinical context was also necessary for the additional level of care provided to her (telephone availability and coaching). For instance, her general introversion, guardedness, self-reliance, and struggles with dependence shame indicated a need for aggressive and proactive therapeutic outreach. In addition, it should be noted that this patient's interpersonal composition is only one of many possible presentations within the heterogeneity of a patient who is chronically suicidal and has BPD. Open, around-the-clock telephone availability would not be recommended with patients exhibiting other traits, such as excessive dependence, histrionic seduction, or antisocial exploitation; these patients would more appropriately require the establishment of very clear limits and firm boundaries, as well as less (if any) additional therapeutic outreach.

DISCUSSION: SUICIDE, LEGALITY, AND THERAPEUTIC LIMITS

Suicide is the most dreaded of psychiatric outcomes. The irreversible loss of life for families, loved ones, and society is irreconcilable. Despite ongoing difficulties in predicting suicidal behavior (Bolton, 2012; May et al, 2012; Black et al, 2004), practitioner liability, though rare, remains a secondary aftereffect (Rachlin, 1984; Maltsberger, 1993; Gutheil, 2004). Clinician concern about this outcome is ubiquitous. Of the more worrisome psychiatric syndromes, personality disorders top the list, particularly BPD (Bertolote and Fleischmann, 2002; Leichsenring et al, 2011). Careful risk stratifications have been proposed (Gutheil, 2004; Fowler, 2012), making clinicians aware of the need to thoughtfully balance predisposing versus protecting factors when determining therapeutic interventions and levels of care. In addition, closer monitoring and more nuanced approaches are often suggested in working with chronically suicidal BPD patients.

Clinicians often enter work with chronically-suicidal BPD patients with multiple personal disclaimers and warnings against becoming overly enmeshed, manipulated, or caught off-guard. Popular suggestions to "set limits" mean well but are problematic because of general patient discomfort with seemingly "authoritarian" stances and disciplinary enforcement (Pam, 1994). Such limit setting runs counter to the very humanism that originally drew practitioners to heal. Further, very little is offered in the literature on just how such limit setting should occur, although psychoanalytic approaches have been proposed (Goldberg, 1984) in which aversive contingencies and "consequences" are indispensable to their efficacy.

The use of such behaviorism has found its hold in newer, interdisciplinary models of care, particularly DBT, which has proven efficacious in reducing acute suicidal behavior and repetitive healthcare utilization (Linehan MM, 2006; Kliem, Kröger, and Kosfelder, 2010). Briefly, DBT is comprised of four treatment components (skills group, psychiatrist, individual therapist/telephone coach, and treatment team conferencing), working in conjunction to reduce maladaptive coping mechanisms such as self-injury, repeated healthcare utilization, or impulsive behaviors (Dimeff and Linehan, 2001). The approach is not only behavioral (with both positive and negative reinforcement as well as close monitoring of antecedents to emotional crises) but is also informed by a blend of cognitive behavioral, Zen Buddhist, and psychoanalytic theories (Koerner and Linehan, 1997). Specific coping mechanisms and skills are learned in groups, though in-person counseling can resemble less behavioral approaches and

may feature affective processing akin to psychodynamic or psychoanalytic work. Although different levels of care can be applied to varying severities of illness (Koerner and Linehan, 1997), DBT has been shown to be most effective in patients with serious functional impairment due to their behavioral patterns (i.e. lower-functioning BPD patients with active self-injurious or suicidal behavior).

Perhaps the most striking departure taken by DBT from traditional, psychotherapeutic practices is telephone coaching. Linehan (2011) describes the many advantages to offering between-session contact to patients, particularly suicidal ones, arguing that individual providers know and can serve their clients much more effectively than can crises centers and hotlines. This phone arrangement requires the therapist is "observing" (rather than "setting") limits, recognizing not only what boundaries to establish in the care but also acknowledging one's therapeutic ceiling and personal needs (Linehan, 2011). Such telephone guidance is meant to be brief, directive, and skill-based. Ben-Porath and Koons (2005) have proposed elegant decision trees that, in order of decreasing priority, minimize suicidal behavior, increase skills application, and process interpersonal conflict or disagreement within the therapy. The preceding case illustrates examples of each of these domains and how they were addressed via in vivo and telephone interventions.

CONCLUSION

Given developments of layered approaches to the chronically suicidal patient with BPD, therapists can be equipped with a more nuanced, therapeutic technique than arbitrary limit setting. Clinician trainees (including psychiatrists and therapists of all types) should be encouraged to explore the limits of their therapies because they are "cushioned" by institutional resources, colleagues with whom they may collaborate, malpractice protection, and supervisory guidance. Of course, this is not meant as an invitation for reckless experimentation, but rather as an opportunity to engage in a heightened level of care in which the dosed variable (the therapeutic alliance) is maximized as one might with any other intervention. With any medication, dose optimization side effects are to be expected; the psychotherapeutic equivalent of excessive regression or dependence is a foreseeable hazard the clinician is prepared for. Maximally titrating a medication can be a difficult, risky, and uncertain process, but psychiatrists all too often engage in such explorations. Failing to optimize the therapeutic alliance itself sells the patient short. One way to titrate such an alliance is through telephone coaching and outreach. This opportunity

was afforded to the author, resulting in a new level of engagement with the patient that proved to be both educational and clinically indicated. The case vignette illustrates risks and benefits associated with expanding on conventional or default therapeutic limits. Without such experiences, it may be argued, budding therapists are seriously limited in developing their clinical armamentarium, especially as the literature continues to offer varied approaches. It is hoped that the case above contributes further insight to the complexities of working with chronically suicidal BPD patients by highlighting the role of the therapeutic alliance and our therapeutic limits.

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