(Escalating self-harm and repeated hospitalizations lead to a change of treaters. The patient quickly connects to the new treater who manages to build an alliance while interrupting her regressive reactions to his absence. This case illustrates the skills required to interrupt a harmfully repeated pattern of hospitalizations, but ends with the equally formidable challenge of helping the patient get on with developing a satisfactory life.)

A. Case Vignette

Laura is a 25 year old female with borderline personality disorder. She is now hospitalized for the eighth time in two years. Both the psychotherapist and the psychiatrist who have worked with her during this time informed the patient and the inpatient case manager that they are no longer willing to work with Laura given her increase in both self-harming and suicidal behaviors over time. [Decision Point 1 (see p. 4)]. You are called to consult on her treatment and explore the possibility of starting as her new psychiatrist [Decision Point 2 (see p. 4)].

Laura is an anxious overweight baby-faced woman who appears both sullen and fearful. She softly explains that she has had a long history of self-harming since the age of 16, when her parents began to have marital problems. You gently ask her to speak up because you’re having trouble hearing her. With a brief smile, she complies. She then described that she cut herself to relieve emotional pain when she was anxious or sad about her parents’ situation, but never told them how she felt. Her parents eventually found out about her cutting through the school counselor and they banded together to help her get treatment. She liked the treater, a social worker, and her cutting decreased. However, when Laura left home to start college, she began
cutting more frequently and eventually began overdosing on medications. Laura reports that in subsequent years she increasingly didn’t care if she lived, since she was often struggling with sadness or anxiety, and with believing she was unlovable and bad. Her overdoses were intended “to make those feelings go away”. These overdoses have involved 10-15 tablets of Prozac, which made her feel ill, but which she knows will not kill her. In response to these overdoses, she had been hospitalized and received medication changes. Her previous therapist and psychiatrist both reported that when Laura was upset she engaged in reckless binge drinking. When they expressed frustration about this, she felt “misunderstood”. Moreover, she would not show up for appointments when she was most distressed and would not call before taking her self-harming or suicidal actions. [Decision Point 3 (see pp. 4)]

You begin a combined psychopharmacology and psychotherapy weekly treatment with Laura. Though she missed some appointments, the treatment generally went well. Laura was active and disclosing and you found her interesting and thoughtful. Laura’s attendance improved and she used email or texting to cancel or alter appointments. She had begun working part time as a dog walker. Three months into the treatment, you go away for a meeting. Laura refuses to see the covering doctor and cuts herself. She sends you an email that she really needs to talk and can’t be safe without you. [Decision Point 4 (see p. 5)]

In the session after you return, you discuss with Laura the events that happened when you were away. In this discussion, Laura says that she has come to depend on you so heavily that she became panicked in your absence and could not imagine anyone else would be capable of helping her. Emphasizing her safety, you reiterate that she needs to be able to use a covering treater when you are away. Laura says “then just put me in a hospital,” and sobbing, runs out of the office. [Decision Point 5 (see p. 5)]
Laura ends up going to the emergency room and accepts voluntary admission into the hospital. She does not self-harm or overdose before her admission. You visit her in the hospital. [Decision Point 6 (see pp. 5-6)]

Over the next six months, Laura’s course is one of inconsistent improvements, though she failed to return to her part time work as a dog-walker. Gradually she comes to trust your good intentions, the use of alcohol stops altogether, and her self-harm fades away. Suicidal ideation is persistent but you no longer worry about her making overdoses. She regresses when you’re away (goes to bed, overeats) and still does not contact the covering doctor, but there are no more hospitalizations. She is stable, but seems to hold her parents hostage via her disability and dependency. She talks about that, but you worry whether she’s going to “get a life”. 
B. **Alternative Responses (Discussion on pp. 1-3)**

(1 = will be helpful, 2 = possibly helpful with continuing reservations, 3 = either not helpful -- or even harmful)

1. **Laura’s inpatient case manager should respond to the prior treaters’ announced intention to terminate their involvement by:**
   a) urging them to reconsider insofar as Laura’s unresponsiveness isn’t their fault. ___
   b) advise Laura that her continued self-destructiveness signals a treatment that hasn’t been effective. ___
   c) assess whether Laura’s escalating self-harm is a result of the prior treatment. ___

2. **In assessing whether to treat Laura, you should:**
   a) ask Laura to sign a written contract that she will not self-harm or kill herself. ___
   b) ask her prior clinicians whether she’s treatable. ___
   c) assess dangerousness, differentiating non-lethal from true suicidal intention. ___
   d) first attain a history of the patient’s childhood in order to understand the developmental sources of her suicidality. ___

3. **After assessing Laura’s suicidality, you should:**
   a) discuss how Laura can help herself when she is in situations or emotional states that lead her to self-harm or overdose. ___
   b) insist on being paged when she is going to self-harm or overdose. ___
   c) indicate that you need to discuss what leads her to self-harm or overdose. ___
   d) ask Laura whether her self-destructive impulses and actions were related to experiences of loneliness or rejection. ___
e) tell her that the safest plan is for her to go to the emergency room when suicidal.
   
   ____

f) express concerns about alcohol use as a risk factor. ___

g) explore why she felt misunderstood by her prior treaters’ reactions and why she didn’t call them before her self-destructive acts. _____

4. **In response to Laura’s desperate email, you should:**

   a) call Laura and insist that she see the covering doctor. ___

   b) call the covering doctor and encourage him/her to contact Laura about her safety. ___

   c) call 911 and have her hospitalized. ___

   d) email Laura and let her know you’re concerned, you want to discuss this more on your return, but in the meantime she needs to either use the covering physician or emergency services. ___

5. **When Laura runs out of your office, you should:**

   a) call the police and have her hospitalized. ____

   b) call after her to come back, assuring her that you agree to discuss whether hospitalization is needed. ____

   c) don’t pursue her, but leave her a message that you are concerned about her safety and you want her to either go to the emergency room or respond to your message. ___

6. **When you meet with Laura in the hospital, you should:**

   a) ask Laura to detail what happened before the self-harm event while you were away and before her abrupt departure from your office. ___
b) invoke a split treatment so that another physician is managing the medications while you continue the therapy. ___

c) explore her apparent dependency on you. ___

d) discuss your dilemma about hospitalization, i.e., that on the one hand it makes her safe, but that it may become (or already has become) regressive and life-interfering. Note that “our failure” (thereby including yourself as part of the problem) to have a constructive conversation about this in your office reflects the fragility of this treatment. ___

e) be concerned about possible liability and seek forensic advice. ___

f) suggest she tell her family about what happened. ___