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At the Bedside

Why Careproviders May Conclude that Treating a Patient Is Futile

Edmund G. Howe

ABSTRACT

I shall examine one way that careproviders may come to judgments of "futility" in cases that are less than clear-cut, in the hope that, if such judgment is unwarranted, it may be avoided.

In this issue of *The Journal of Clinical Ethics*, in "Repetitive Foreign Body Ingestion: Ethical Considerations," Sarah Lytle, Susan J. Stagno, and Barb Daly describe a 19-year-old patient who is as badly off as a patient can be. She has swallowed a knife blade—*again*. Careproviders balk when asked to remove it. One reason is that they see removing it *again* as futile—or at least too futile to warrant "the costs."

This view may not be uncommon. One researcher, for example, says that medical students and "physicians in training" are taught this kind of response in a "hidden curricula."¹ They are taught, he says, that some patients are "more deserving than others," and this translates to the provision of compromised care to the "less deserving."² Eventually, he says, physicians recognize the "ultimate authority" of us-

ing moral judgments to determine how they should discriminate among patients:³ patients must comply with the values of the hospital to be fully "worthy of care," and that this worthiness should determine "which patients to see, for how long, which tests to order, and which treatments to offer. . . ."⁴

How careproviders responded in this case may be an example of this. If there is "hidden" teaching as the researcher claims, this is frightening; especially so, because the patients that careproviders would judge as "less deserving" may be among those worst-off. Therefore, this essay will examine one way careproviders may come to judgments of "futility" in cases that are less than clear-cut, in the hope that, if such judgment is unwarranted, it may be avoided.

In the case above, the patient has symptoms characteristic a diagnosis of a borderline personality disorder (BPD).⁵ In a nutshell, patients with a BPD tend to be "stably unstable." For example, this patient swallowed knife blades repeatedly and now threatens her careprovider. But it is possible for these patients to do well, and this judgment of futility is simply wrong.

Why might such a chain of events occur?⁶ The answer is important to *all* careproviders, psychiatric and nonpsychiatric, who may find themselves considering whether a patient's treatment is futile, or too futile to warrant "the costs." How careproviders might come to a

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judgement of futility, erroneously, without even imagining that they are doing so, may be instructive to all careproviders.

I will consider patients with a diagnosis of a BPD as “paradigmatic patients,” to show how patients with such symptoms may evoke fear and anger in careproviders. Such feelings may prompt careproviders to distance themselves from these patients—even only internally—and to judge treating them as futile. To rationalize this judgement, careproviders may then deny the validity of any additional data that might refute what they are thinking and doing.

I will describe what a patient with a diagnosis of BPD needs, ideally, and give three specific examples of questions for careproviders to consider when they treat these patients, who may, especially early on, feel suicidal.

Finally, I will report on new research findings and consider their practical implications for careproviders who may be in a position to make decisions regarding futility.

HOW PATIENTS WITH A BPD MAY EVOKE FEAR AND ANGER

Sometimes it seems as though it is a small percentage of patients who need the most help. Patients with a BPD, like the patient who swallowed a knife blade, are surely among these.

Patients with a BPD

The patient who swallowed a knife blade had done so before, and threatened a careprovider after the careprovider suggested that surgically removing the knife blade, again, might constitute futile treatment, given the costs of the surgery and the likelihood the patient would swallow the blade again.⁷ Baum-Baicker and Sisti report the case of a patient who called her psychiatrist one night to say she was standing in a bathtub full of water and was about to drop her running hair drier into it.⁸ My colleagues relate the case of a patient who was discharged from a psychiatric ward, picked up the medicines prescribed to her, ate them all, called the ward, told the staff what she had done, and refused to say where she was. Fortunately, she was found and survived. These examples illus-

trate why careproviders may respond to patients with a BPD with fear and anger. This is particularly so, because, as Lytle, Stagno, and Daly note, the patients’ risk of attempting and succeeding in committing suicide is much increased.

If, due to fear or anger, careproviders distance themselves, this is the opposite of what the patients most need. Distancing makes the patients worse and can trigger their feeling acutely suicidal, because it may leave them feeling abandoned.⁹ I shall now describe this in somewhat more detail.

How Careproviders May Respond

Careproviders who see a patient like the one who swallowed the knife blade may have strong feelings of fear and anger, which may reduce their capacity to care for patients. Later in this essay I will outline new research findings that suggest that careproviders may have greater capacity to control, and even to eliminate, such fear, at least over the longer run, than previously known.¹⁰ This capacity may extend to fear in the short term, and to anger, as well.

The research suggests that people may actually be able to erase fearful memories, rather than being able to just suppress them. This is critically important, because if fearful memories remain with us, as they were thought to do before this research was reported, they may harm patients in two ways: first, they may re-emerge and cause distancing later, or they may “fester” and cause distancing “all of the time.”

The second finding is of great importance: that feelings of fear cannot be erased when a feared outcome remains uncertain.¹¹ This is more likely the case for patients who are “stably unstable” or who are “chronically suicidal.”¹² Fearful memories may stem from a careprovider’s feelings of empathy; that is, the stronger a careprovider’s fearful or angry feelings are, the more likely it is that the hurt is caused by imagining what a patient has been—and still is—going through.

Medical students and physicians in training often are told that they shouldn’t take their patients’ problems “home with them.” But such a capacity to “compartmentalize” one’s feelings may, in part, be genetically based. As a geneti-

cist once said to me, for example, “Not all people can, to the same degree, argue with their spouse over breakfast and then carry on later at work as if nothing had happened.” Some careproviders are much less successful than others at not taking patients’ problems home with them. If so, these may be the careproviders who are more vulnerable to feelings of fear and anger. These careproviders, who are the most empathic, may be those who most distance themselves. They may be most likely to unconsciously try to justify such distancing, to wrongly rationalize that treatment would be futile. Thus this sequence may include fear and/or anger, followed by avoidance, rationalization, and denial.

Avoidance

People typically respond to fear and anger by avoiding cues that re-elicite the painful feelings. Avoidance “rewards them” by giving them relief from their pain, by enabling them to avoid cues that would re-evoked painful feelings. As noted above, new research reports that we may be able to erase the fearful memories that feelings create. If we can recall the memories, we may be able to “update” them so that the memories are changed and rendered “safer.”¹³ This strips them of the capacity to continue to cause us pain—pain that can effect how we treat our patients. A capacity to erase fearful memories makes sense from the an evolutionary standpoint: to survive, our ancestors had to be able to update “old” fearful memories. For example, our ancestors might have needed to forage for food in places where they had previously experienced fear. If they couldn’t update and make their memories safer, the number of places they would be able to forage would shrink and they might starve. The new research suggests that a way we may be able to overcome and erase fears is to “revisit” them in some way, and see them with a different, safer meaning. Thus, there may be a second harm if previous experience with patients evokes fear and causes us to distance ourselves from or avoid current patients: there may no new experiences allowing us to update, render safe, and erase fearful memories. We will not have the opportunity to “self-heal.”

When a careprovider concludes that a patient’s treatment is futile or doesn’t warrant its cost, it may be the result of distancing and avoidance. And the feelings may re-emerge later or “fester.”

Rationalization

We are all capable of rationalizing what we feel when we are entirely in error, without being aware that we are doing it.¹⁴ Thus, if a careprovider avoids a patient due to fear or anger that is based on previous painful experience with a patient, the careprovider may rationalize these feelings, so that they seem justifiable. For example, a careprovider might find an explanation to justify not treating a patient, saying treatment is futile or not worth the cost.

Denial

Likewise, we may all engage in “denial” and not know it. V.S. Ramachandran states, for example, that we may engage in denial at “any given moment of our waking lives.” He says that doing this lies at the heart of our human nature; we do this whether we are “temporarily ignoring bills” or “defiantly denying our death.”¹⁵ He believes that we may do this so that our brain can provide us with a “coherent perspective.” He proposes that we need to be able to make up for ourselves a false yet believable “belief system” or story.¹⁶ Such denial occurs without our knowing or willing it. A part of the brain that produces denial may have been located.¹⁷ This “model” of denial, Ramachandran concludes, rests on the notion that we need to be able “shut off information” at times, to eliminate threats that otherwise would be too overwhelming to us.¹⁸ Denial may be the last straw that impairs a careprovider who wants to help a patient with a BPD. The careprovider may be unable to see there is hope for the patient, and how much hope there actually is.

WHAT, IDEALLY, PATIENTS WITH A BPD NEED

When careproviders have continuing fear or anger, it may interfere with their ability to give patients the care they need to get better. Fester-

ing fear may (whether it is unconscious or not) result in careproviders' distancing themselves from patients, as noted above. What might ideal care for these patients be?

How Careproviders Might Ideally Respond at First Meeting a Patient with a BPD

Ideally, careproviders should respond in a way that communicates that they are not judging a patient with a BPD, that they are committed to doing all they can for the patient, and that there are grounds for hope. Not judging patients may be the hardest. For example, careproviders might believe that a patient is "responsible for his or her actions," and tell the patient this. Lytle, Stagno, and Daly note, for example, that they believe this when patients have dissociation that is less severe, but this may or may not be so. Patients may say that they can't predict or control what they do. I will return to the practical issue this raises when I discuss "contracting for safety," shortly.

What might be the connotation to these patients of saying this? Patients may see this, implicitly at least, as blaming them. This especially may be the case when patients feel that they lack control.¹⁹ What might a careprovider say to a patient like the one who swallowed a knife blade on first meeting? Perhaps: "I'm so sorry you did this and that you will have to go through our removing it," and, "It may be that, later, together, we can learn better what might have moved you to do this. If we can, we may know better what you need to know so it won't happen again."²⁰ Perhaps, in addition, "How do you feel, right now? How bad is your pain?" And finally, "You have been through this before. Is there anything you can tell us that could make your experience better, or less worse?"

The Key Principle in Treating BPD Patients

A key principle—beyond initially being nonjudgmental, conveying commitment, and communicating hope—is starting from wherever a patient "is at," as opposed to rigidly adhering to a standard approach. This may involve going outside one's "usual" way, as opposed to insisting that a patient "comes to us." One example would be a careprovider's considering

coming to a patient's home. That is, should a careprovider, with or without other members of the team, ever come to the patient's house, if a patient will not come to the careprovider?

Coming to a patient's home, even only once, may be enough to enable the patient to succeed. For example, in one instance, members of a care team told a patient, over the phone, that unless he came in, they would *all* come to his home. He pictured the team, he said later, all sitting around him as he lay in bed. He came in. This approach applies equally to other sorts of patients. For example, patients addicted to alcohol may refuse to go to Alcoholics Anonymous, especially initially, on their own, but may be willing to go if someone will pick them up and go with them. A careprovider, in this instance, most likely, should do this.

What Careproviders Might Additionally Consider When Patients Are Suicidal

When patients with a BPD are suicidal, going "the extra mile" may be especially important to try to keep them from suicide. One could say that this is wholly their choice, but this may be mostly self-serving and not quite, entirely, the case. It is true that careproviders are most vulnerable to responding to such patients with fear and anger. I will give three examples of going "the extra mile," of interventions that careproviders might want to consider in such circumstances. Readers might want to imagine the difficulty they might feel in trying to decide whether to go the extra mile in these cases.

Not Hospitalizing Patients

There is a high risk that these patients will become worse if hospitalized, especially for longer periods of time.²¹ Careproviders who want to help them may have to be willing to take the risk of not hospitalizing them, even when they feel suicidal. I recall a patient I saw who said that she surely would kill herself if I hospitalized her involuntarily—she had already tried out the knot she would use to hang herself. I arranged with her to not hospitalize her. Instead, I called her several times throughout the day. Luckily, this succeeded. In other situations, similar sharing of decisions with patients

may be optimal, although, likewise, more “risky.” An example might be that of a careprovider who does not push to start a patient who has schizophrenia on an antipsychotic medication when the patient opposes it. Some advocates of sharing decisions and not starting a medication under these circumstances believe that this approach preserves and even improves the patient/careprovider relationship, and note, “Some [psychiatrists] believe that . . . paternalism is often necessary. . . . Our bias is to adopt a radically more collaborative style.”²²

Phone Issues

A second set of difficult ethical and clinical issues involves use of the phone: Should a careprovider always be available? What should a careprovider say when a patient, feeling suicidal, calls? How much should a careprovider say in advance about what she or he will say if the patient calls feeling acutely suicidal? For example, a careprovider may not always want to be available by phone; among other reasons, this can be very stressful. Should a careprovider for this reason—as a “tie-breaker” for them—decide to not always be available?²³

If a careprovider is not always available to patients for this reason, should they tell patients this? How should a careprovider respond when a patient calls, feeling suicidal? Should the careprovider try to “talk the patient down”? Or should the careprovider recommend that the patient go at once to an emergency room? If a careprovider tries to talk a patient down it may fail, and the careprovider, most understandably, may fear this. But if a careprovider won’t try to talk the patient down, and tells the patient this ahead of time, the patient may see no reason to call, and the risk that the patient will commit suicide may increase.

Contracting for Safety

Not infrequently, careproviders ask patients with a BPD to agree in writing that they will not try to end their life. This is called “contracting for safety.” Hospitals often “require” careproviders to ask patients to sign such an agreement. But some patients respond that they cannot in good faith say they will not attempt

suicide in the future, if they experience an overwhelming impulse to do so. This creates two problems. First, careproviders may be asking patients to agree to do something that they don’t think they can do. Second, even if patients feel they can do this, being asked to sign an agreement, as if it were a legal contract, may impair their trust. There are no data indicating that these contracts reduce the risk of suicide.²⁴

There is anecdotal evidence from careproviders that, if they pressure patients to sign such a document, they will lose the patients’ trust. For example, one careprovider asked a patient to sign a contract prior to releasing him as an outpatient, and the patient refused. The careprovider said, “Okay,” and the patient did well. The careprovider, however, continues to ask himself, to this day, “What if this patient had killed himself?” Given this, should careproviders ask patients to “contract for safety”? Should they explain that they are asking to meet the “demands” of the hospital? It may be that not pressuring patients or explaining why they are asking for a contract is the best way to maintain a relationship with a patient, but, if they do explain, they may have to do it “in the closet” to avoid later questioning from their hospital.

IMPLICATIONS FOR CAREPROVIDERS

Careproviders may feel fear and anger at patients for many reasons. They may feel fear or anger, for example, because they care very deeply about their patients. Alternatively, careproviders may have such feelings for many other reasons. For instance, they may fear “the law.”

This may be one reason careproviders ask patients to sign anti-suicide contracts—they may hope that this will protect them legally. Such fear—as for any fear—may cause careproviders—as all people—to reason wrongly. For example, the cardinal rule for not being sued is, “Always do what is best for your patients.” Careproviders may not do this, but instead do what they think will best protect *them*.²⁵ This may unwittingly leave them at a much higher risk. For example, careproviders may fear disapproval or even censure from colleagues for providing treatment to a patient that is futile or

does not warrant the cost, as the careprovider felt in the case of the patient who swallowed a knife blade.

Careproviders may be able to “erase” a fear, as I noted above, by returning to a fear memory and find a safer meaning in it. Daniela Schiller, a researcher in this area, describes two possible ways to do this: by retelling one’s “story” in a way that puts one “more in charge,” and through creating artwork.²⁶ That makes sense. It’s what children do when they conquer feelings of fear and anger by retelling their stories using puppets or by making drawings. An adult example of this may be Isabelle Allende, the critically acclaimed author, who says writing helps with her “demons” and “obsessions.”²⁷

What might careproviders do to try to reduce feelings of fear or anger in response to patients like the one who swallowed a knife blade, when they first occur, and then later, over time? There are many things to try, both with and without the help of others. To consult with colleagues and then document this is the common and probably soundest advice. It has been recommended specifically for careproviders who treat patients with a BPD.²⁸ There may be other ways that can enable careproviders to acquire the emotional benefits they want—as well as relief—on their own. They might retell their story, as Schiller suggests, as in a diary. The test of whether or not they have succeeded would be how they feel.

Reversal

What might careproviders try on the spot, for example, the first time they see patients with a BPD? They can try “turning the tables.” They can ask themselves what they would feel in the patient’s shoes. Doing this is not that unusual. But they could enhance the effect within themselves by imagining sitting in the patient’s chair and talking to a careprovider. This approach is one that Raymond Corsini, a therapist for “some 50 years” or so, has used with patients who were “rejecting” him. He asked them to switch chairs and then left the room, saying, “When I return, you will be me and I will be you.” He then acts as he would if he were this “client.” When this procedure works,

he says, it “works well,” and, sometimes, he adds, this “reversal” has worked “miracles.”²⁹

Understanding

Numerous studies have documented that it is easy and common to presume, when we see another person “misbehaving,” that the other person’s behavior is entirely attributable to who the person *is*, rather than to the person’s life circumstances.³⁰ As careproviders, we can seek to better understand others who seem to be acting badly. Paris, a leader in treating patients with a BPD, exemplifies this in his work to understand why some patients with a BPD are chronically suicidal.³¹ He concludes that the patients may want to escape suffering—which may be easy to imagine, thinking about the patient who repeatedly swallowed a knife blade. These patients may feel that careproviders will not sufficiently try to help unless they attempt suicide, and they may want, by doing this, to feel more in control. This last goal is in line with the new research findings that are cited above.

In this context I think of so-called “cutters”—patients who cut themselves. They often report that cutting helps them to feel better, by helping them to feel more in control. Steven Levenkron, a psychotherapist, asks, “What priority exists for the self-mutilator, or cutter, which allows her to bypass her body’s own defenses and ignore the pain?” and answers that a cutter must experience her own “necessities, urgencies and dangers” as being as intense and real as the “sight of a drowning child.” The cutter then feels the need to rescue the child, even from cold water,³² “even in ice cold water.”

In this regard, I think of how an attempt to understand helped a patient who had been terrified of an in-law. She learned that this in-law had been abandoned by both parents, at separate times, when he was a child. Then, she said, she felt “only compassion” for him. When patients with a BPD are impulsive (or as psychotherapists say, “act out”), it is often, experts believe, in response to what they perceive as another person’s “slighting” them. This presents a strong rationale for a careprovider to continue to see such patients after they have tried to take their life or, like the patient above, have swal-

lowed a knife blade—again. A careprovider who is willing to continue to see such patients can explore with them what the patients have experienced as a deep, interpersonal slight—especially since the careprovider may be perceived as the source of the slight! The above patient’s threatening her careprovider may be an example of this.

Humor—A “Quick Fix”

There is a possible “quick fix.” A careprovider may be able help a patient see how he or she is reacting, or overreacting, by using a different, humorous point of view. This worked miraculously with one of my patients. He came to see me in a panic. He was scheduled to have surgery to replace a knee, but he had just lost confidence in his surgeon, because, he said, she had “mocked” him. I asked him what had happened. He said that while he was sitting in the surgeon’s waiting room, another patient coughed “on him,” not covering his mouth. My patient said that he feared he could get pneumonia, and told this to the surgeon’s receptionist. When he then saw the surgeon, she smiled and then turned her head away and coughed loudly. “But it was a fake cough,” he said; “she was mocking me.” Then he told me he had also seen patients in the surgeon’s waiting room who had tattoos. “Maybe this surgeon isn’t so good,” he said, “Maybe these patients just can’t afford anyone better!”

I asked him to “just bear with me” for a moment. I clicked on a ball point pen, rolled up a sleeve, and started to draw a tattoo on my arm. “I got it,” he suddenly said, roaring with laughter. “She was not laughing *at* me. She was laughing *with* me. She was trying to put me at ease.” He said he was all better then. Actually, he said, he was “*more* than better.” He left, and had the surgery. With, of course, this surgeon.

CONCLUSION

Careproviders may feel fear and anger toward patients, and, as a result, even unwittingly, cause them harm, by distancing themselves, which may make the patients feel worse. A careprovider may do this, unknowingly, by telling

him- or herself that treating such patients is futile or not worth it. Careproviders may then rationalize this erroneous conclusion and deny any data that refute it.

Careproviders who are aware of this risk may try to overcome these feelings. New research suggests this may be more possible than previously understood. Careproviders might try to change their feelings of fear and anger as they become aware of them or try to “consult and document” as a response. They could, alternatively, try reversing roles with a patient, or try to understand things that don’t make sense to them, or seek to view how they are reacting from a different, possibly even humorous point of view. Most remarkable, and hopeful, in this regard, is the extent to which their trying any of these things may enable them to succeed.

Here is a final example of how this may work, from one of my patients. Her husband has Alzheimer’s disease, and was often nasty to her. She retaliated by being nasty back, reasoning, “He’s nasty to me on purpose.” Over time, I tried to convince her this might not be the case, and she perhaps could give him the benefit of the doubt. She decided she would try it. I saw them both recently. Now he doesn’t remember what he has said as soon as he’s said it, but still says, smiling, to her, “I love you.” When I left them, I said to her, “He is so lucky to have you.” She said, “No. *I* am so lucky I have *him*.”

MASKING

I have changed details of examples to protect the identity of individuals.

NOTES

1. The “hidden” curriculum, as used here, refers to a cultural process in medical education through which medical students learn value judgments that “enable them to act within a moral economy of care.” R.T. Higashi et al., “The Worthy Patient: Rethinking the ‘Hidden Curriculum’ in Medical Education,” *Anthropology & Medicine* 20, no. 1 (2013): 13-23, 14.

2. *Ibid.*, 15.

3. *Ibid.*

4. *Ibid.*, 22.

5. This diagnosis, as many in psychiatry, is a category made up of many symptoms, as opposed to a proven entity.

6. This may have occurred, alternatively, because the initial careproviders weren't familiar with the relatively recent findings suggesting that these patients have a much better prognosis than previously believed. This new data is provided in S. Lytle, S.J. Stagno, and B. Daly, "Repetitive Foreign Body Ingestion: Ethical Considerations," in this issue of *JCE*.

7. K.R. Berenson et al., "The Rejection-Rage Contingency in Borderline Personality Disorder," *Journal of Abnormal Psychology* 120 (2011): 681-90.

8. C. Baum-Baicker and D.A. Sisti, "Clinical Wisdom and Evidence-Based Medicine Are Complementary," *The Journal of Clinical Ethics* 23, no. 1 (Spring 2012): 13-27, 20.

9. J. Paris, "Half in Love with Easeful Death: The Meaning of Chronic Suicidality in Borderline Personality Disorder," *Harvard Review of Psychiatry* 12, no. 1 (2004): 42-8.

10. D. Schiller, "Extinction During Reversal and Reconsolidation of Rear Memories is Different from Standard Extinction," presentation at the 8th Annual Conference on Amygdala, Stress, and PTSD, Uniformed Services University of the Health Sciences, Bethesda, Md., 23 April 2013.

11. In Schiller's presentation, this point concerning uncertainty was underlined in her PowerPoint presentation. This was the only underlining in the presentation. *Ibid*.

12. See Paris, note 9 above.

13. See Schiller, note 10. "What could we do with such a technique? Mind reading," from D. Schiller, "Affective Neuroscience: Tracing the Trace of Fear," *Current Biology* 21, no. 18 (27 September 2011): R 695-6, R695.

14. J Verwoed et al., " 'If I Feel Disgusted, I Must Be Getting Ill': Emotional Reasoning in the Context of Contamination Fear," *Behaviour Research and Therapy* 51, no. 3 (March 2013): 122-7.

15. V.S. Ramachandran and S. Blakeslee, *Phantoms in the Brain* (New York: Harper Perennial, 1998), 136. Denial is most common in certain kinds of strokes, but it may occur in people who have no brain damage. For example, women, on rare occasions, come into the emergency room, "complaining of" stomach pain, but are delivering a baby and haven't known they are pregnant.

16. *Ibid.*, 134.

17. *Ibid.*, 142.

18. *Ibid.*, 151.

19. Dialectical behavior therapy, a leading treat-

ment for patients with a BPD, requires therapists to meet, often, together, to examine harmful assumptions and unwitting connotations that they may be making, that they may not know they are harboring, and may unwittingly convey to patients. B. Long and S. Witterholt, "An Overview of Dialectical Behavior Therapy," *Psychiatric Annals* 43, no. 3 (April 2013): 152-7, 154.

20. This response may be optimal for patients who have addictions, since their "relapsing" may be triggered by cues that they don't know exist.

21. See Paris, note 9 above.

22. C. Gordon and M. Green, "Shared Decision Making in the Treatment of Psychosis," *Psychiatric Times* 30, no. 4 (April 2013): 33-4, 48, 33.

23. It has recently been reported, anecdotally, that patients may do better if they can always call. See note 19 above, p. 156.

24. M. Goodman et al., "Suicidal Risk and Management in Borderline Personality Disorder," *Current Psychiatry Reports* 14 (2012): 79-85.

25. In one study, for example, 85 percent of careproviders said they had done this. R. Krawitz and M. Batcheler, "Borderline Personality Disorder: A Pilot Survey about Clinician Views on Defensive Practice," *Australas Psychiatry* 14 (2006): 320-2. Careproviders may also believe that if patients make this "promise," they will be more likely to honor it and not take their life.

26. See Schiller, note 10 above.

27. E. Wax, "Love, Liberation, and Achoo!" *Washington Post*, 14 May 2013, C1-4, C4. For example, her daughter, Paula, died, at age 28. Allende wrote a memoir about her.

28. T.G. Gutheil, "Suicide, Suicide Litigation, and Borderline Personality Disorder," *Journal of Personality Disorders* 18 (2004): 248-56.

29. R.J. Corsini, "Turning the Tables on the Client: Making the Client the Counselor," in *Favorite Counseling and Therapy Techniques*, ed. H.G. Rosenthal (New York: Brunner-Routledge, 1998), 55-7.

30. T. Brosch et al., "Neural mechanisms Underlying the Integration of Situational Information into Attribution Outcomes," *Social Cognitive and Affective Neuroscience* (9 May 2013.)

31. See Paris, note 9.

32. S. Levenkron, *Cutting* (New York: Norton, 1998), 41.