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Chronic self-Injury and suicidality in borderline personality disorder and Its treatments

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CHRONIC SELF-INJURY AND SUICIDALITY IN BORDERLINE PERSONALITY
DISORDER AND ITS TREATMENTS

by

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ABSTRACT

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CHRONIC SELF-INJURY AND SUICIDALITY IN BORDERLINE PERSONALITY
DISORDER AND ITS TREATMENTS
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This study examines the ethical considerations and ways of treating chronic suicidality in

people with Borderline Personality Disorder. A sample of 62 clinicians working in the

mental health field was surveyed. As predicted, the degree held by the participant, the

type of organization the participant worked for, their occupation/title, type of treatment

modality and years of experience were all related to how they responded to the questions

on the survey. Unexpectedly, the sex of the participant was also related to how

participants responded.

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CHAPTER I

Introduction

The current study aims to examine the ethical considerations involved in treating individuals with Borderline Personality Disorder (BPD) who exhibit chronic self-injurious behavior, multiple suicide attempts and repeated threats of suicide, both real and parasuicidal. There are multiple treatments shown to be effective in reducing self-injurious behaviors and there are some treatments shown to be efficacious in the treatment of BPD. However, there are few empirically validated treatments and many can be difficult to apply in certain settings. It can be difficult to distinguish between an acute and chronic risk of suicide in people with BPD. In addition, it can be complicated to ensure the safety of clients with BPD without utilizing the hospital and yet it may be counter-therapeutic to frequently use the hospital to minimize risk. Therefore, the question of beneficence and the duty to do no harm arises when considering how to balance safety while providing the most effective treatment in outpatient settings. Questions of competency, autonomy and informed consent also require great consideration in handling suicidal risk.

The goal of this study is to collect data from psychiatrists, psychologists, counselors and social workers who work with this population in order to determine what they believe to be best practice when balancing the safety of clients with effective long-term treatment of BPD and chronic self-injurious behavior and suicidality. The ethical standards as presented by the American Psychiatric Association, American Psychological

Association, American Counseling Association, National Association of Social Workers as well as the American Association for Marriage and Family Counseling will be reviewed. The New Jersey state laws and examples of court cases pertaining to managing suicidal behavior will be examined. A review of the current literature on empirically validated and effective treatments for BPD will also be considered in determining the recommendations for practitioners working with this population.

Borderline Personality Disorder

The Diagnostic and Statistical Manual IV Revised or DSM IV-R (2000) is perhaps the most commonly used system for making diagnoses of mental health disorders. Every diagnosis includes an assessment on five levels called the Multiaxial Assessment. Axis I describes clinical disorders and the primary focus of treatment, while Axis II contains Personality Disorders and any Mental Retardation or Learning Disabilities. Axis III consists of medical conditions and Axis IV describes stressors or environmental problems. Lastly, Axis V is a numerical value assigned to illustrate level of functioning. Borderline Personality Disorder is an Axis II diagnosis and is classified as a Cluster B Personality Disorder in the DSM IV-R (2000). According to the DSM IV-R (2000), Personality Disorders cannot be diagnosed if the symptoms are better explained by another mental disorder. The symptoms must not be due to substance use/abuse or a medical condition. The symptoms must be able to be traced back to adolescence or early adulthood and they must be visible in multiple facets of life (i.e. school, work, personal and social situations). The symptoms must cause clinically significant distress or impairment in daily functioning and the symptoms must deviate from the expectations of the person's culture. There must be a disturbance in at least two of the following areas: a)

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cognition b) affectivity (i.e. emotional response) c) interpersonal functioning and d) impulsivity.

More specifically, BPD is characterized by unstable relationships, self-image and affect as well as poor impulse control. According to the DSM IV-R (2000), five of the following criteria must be met in order for the diagnosis to be made:

1) Frantic efforts to avoid real or imagined abandonment (not included in Criteria five), 2) A pattern of unstable and intense interpersonal relationships characterized by alternating extremes of idealization and devaluation, 3) Identity disturbance: markedly and persistently unstable self-image or sense of self, 4) Impulsivity in at least two areas that are potentially self-damaging (i.e. spending, sex, substance abuse, reckless driving, binge eating) (not included in Criteria five), 5) Recurrent suicidal, gestures, threats, or self-mutilating behavior, 6) Affective instability due to a marked reactivity of mood, 7) Chronic feelings of emptiness, 8) Inappropriate, intense anger or difficulty controlling anger, 9) Transient, stress related paranoid ideation or severe dissociative symptoms (DSM IV-R, 2000, p 710).

Multiple assessments have been developed by various professionals to help assess the symptoms of BPD. There is a Borderline Symptom List 23 (BSL-23), the Minnesota Multiphasic Personality Inventory –2 and many others which have been developed to help make a diagnosis. However, these measures alone cannot confirm a diagnosis; a trained mental health professional must conduct an interview and make a diagnosis based on an individual's history and current patterns of behavior. Marsha Linehan who is a leader in the treatment and research on BPD utilizes measures she helped create to assess parasuicide in BPD. They are the Lifetime Parasuicide Count (LPC) and the Parasuicide

History Interview (PHI) which gather information about any suicide related event from the first time to the present day. The measures help gather details about the frequency, severity, intentions, social context, and trigger events etc around the suicidal behavior. This is beneficial because suicidal behavior is so frequent in BPD.

Self-Injurious Behavior, Parasuicide, Chronic Suicide and Acute Suicide Defined

"Suicide is defined as self-injurious behavior with a fatal outcome for which there is evidence (either explicit or implicit) that the individual intended at some (nonzero) level to kill himself or herself" (Links, Gould, & Ratnayake, 2003, p. 302). Completed suicide includes the intent to die. However, there are many other types of self-injury that can occur and they vary in the intention, level of intensity and level of risk. Thus, a distinction is required to be made among terminology describing these different acts.

Particularly in individuals with BPD, there can be a vast range in level of intent in regards to self-injury. It can vary from full intent to some intent to zero intent to end one's life. A suicide attempt is explained as "self-injurious behavior with a nonfatal outcome for which there is evidence (either explicit or implicit) that the individual intended at some (nonzero) level to kill himself or herself" (Links, Gould, & Ratnayake, 2003, p. 302). Links, Gould and Ratnayake (2003) differentiate this from "self-injurious behavior not intended to be fatal" which would mean zero intent to die (p. 302). Linehan further distinguishes suicide attempts as ambiguous and unambiguous to clarify the intention (Brown, Comtois, and Linehan, 2002). Guo and Harstall (2004) describe suicide attempts as anything from a suicidal gesture or manipulation to a deliberate, actual attempt that is not fatal but without intervention by others can be harmful. According to

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multiple sources referenced in Brown, Comtois, and Linehan (2002), when someone intends to end their life, the most frequent reason is to escape from what is causing their distress. Often, individuals also believe that they are making things better for others by committing suicide (Paris, 2004)

"Not all patients who are depressed are suicidal, nor are all patients who are suicidal, depressed. To the contrary, teasing out suicidal tendencies secondary to severe depression from suicidal tendencies that are characterologically anchored and not linked to depression is crucial to a differential diagnosis" (Kernberg, 1993, p. 245-246). The term parasuicide is used frequently to describe a type of self-harm with zero or minimal intention to end one's life. It is also called non-suicidal self-injury (Paris, 2004 and Brown, Comtois & Linehan, 2002). Brown, Comtois, and Linehan (2002) define parasuicidality as "deliberate self-injury or imminent risk of death with or without the intent to die" (p. 198). In the World Health Organization (WHO) Report, parasuicide is defined as a deliberate act that is not intended to be fatal which is expected to result in self-harm (Guo & Harstall, 2004). It is a broad term that encompasses any type of gesture, threat or act that is not intended to be fatal. This difference in intent requires a different approach to treatment, as Kernberg was suggesting.

The term self-mutilation can be closely linked with parasuicidal behavior as well. It is another form of self-injury which "involves superficial cuts on the wrists and arms, actions not associated with serious danger" (Paris, 2004, p. 42). Paris (2004) continues to describe self-mutilation as "less lethal, and their suicidal ideals tend to be more chronic" (p. 43). Brown, Comtois and Linehan (2002) describe it as non-suicidal self-injury with the self-harm being the sole intent, not suicide. Hayakawa (2009) calls it non suicidal

self-mutilation or "wrist-cutting syndrome, a condition characterized by repeated, superficial wrist cutting in a non-suicidal fashion" (p. 41). Lastly, Fine and Sansone (1990) report that "cutting, burning, hitting, and/or biting oneself; purposeful sun burning; hair pulling" are examples of self-mutilation.

There are a variety of reasons and theories behind why someone would engage in parasuicide or self-mutilation. One of the primary reasons is for emotional relief or to reduce distressing internal states (Brown, Comtois & Linehan, 2002). Paris (2004) states something very similar, it "provides short-term regulation of intense dysphoric affects" and can "function as a distracter, substituting physical for mental suffering" (p.43). It can also provide an escape, a distraction or avoidance according to Brown, Comtois and Linehan (2002). They also propose that it can help to generate feelings and provide expression for the turmoil experienced within (Brown, Comtois & Linehan, 2002). Gunderson also suggests that self-injury can help to reduce anxiety or organize a fragmenting self (Fine and Sansone, 1990). It can also help end dissociation for individuals who experience this as a symptom (Brown, Comtois & Linehan, 2002).

Another major reason for non-suicidal self-injury is for self-punishment. Paris (2004) and Brown, Comtois and Linehan (2002) both state that expressing anger or punishing one's self can be the intent. Brown, Comtois and Linehan (2002) claim that this "fits with Linehan's (1993) theory that parasuicidal individuals learn from their environments to punish, disregard, or otherwise invalidate themselves in extreme ways" (p. 201). Gunderson, as stated in Fine and Sansone (1990) also believes that non-suicidal self-injury may act as a method of punishing a perceived bad self.

A third theory about why individuals with BPD may engage in parasuicidal

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behavior is because of the secondary gain that may come from it. Gunderson, as explained in Fine and Sansone (1990) says that individuals do it for the care, concern and/or attention that others show in response to parasuicidal behavior. Kernberg (1993) believes that "their self-destructive behavior is not related to severe depression, but emerges as a frequent concomitant of temper tantrums, explosive outbursts, sudden mood swings, or in more or less subtle ways of manipulating or imposing their will on the environment" (p. 247) . Many researchers have noted that the secondary gain (attention) an individual might get from parasuicidal behavior may at times be a motivating factor in continuing to engage in the behavior. It is another factor to consider when treating the parasuicidal behavior as it would be harmful to positively reinforce this behavior.

The level of risk can also vary greatly. However, this is often a difficult level to distinguish. Acute risk of suicide is what most clinicians are familiar with and trained to respond to. Acute risk is "short-lived (days or weeks), with the client becoming safe after a vigorous protective treatment intervention usually in a secure environment" (Krawitz, Jackson, Allen, Connell, Argyle, Bensemann, & Mileshkin, 2004, p. 12). Fine and Sansone (1990) describe acute risk of suicide as needing the "management of the short – term crisis is needed until the self-destructive phase passes" (p. 163). Acute risk usually refers to a high level of risk with a perceived genuine intent to end one's life. However, not all suicide attempts or all self-injury or verbal threats of self-injury can be defined as acute risk.

In BPD, it is common for clients to exhibit a chronic risk of suicide. Paris (2004) defines the term chronic suicidality as criteria five from the DSM IV-R which describes recurrent self-injury and suicidality. Fine and Sansone (1990) describe it as the

individual's way of adapting to life. The self-injury or suicidal behavior has become the individual's response to handling certain emotional states. Paris (2004) claims that it serves three functions. The first is that it can help them to dealing with painful emotions as they may wish to escape inner suffering (Paris, 2004). Secondly, it may serve to communicate distress, particularly if the individual thinks it is the only way they will be heard and paid attention to (Paris, 2004). Lastly, it can be done in effort to establish a sense of control particularly if the person is feeling empty (Paris, 2004). Favazza, as described in Fine and Sansone (1990), explains that the "chronicity of these behaviors may promote and maintain a sense of personal identity as well as provide for an immediate outlet for displaced anger" (p. 161).

The issue is further complicated as research describes a state known as an "acute on chronic risk" (Links, Gould & Ratnayake, 2003, p. 307). Individuals with BPD may actually go through genuine acute periods of suicidality, most often when they have a comorbid Axis I disorder (Fine and Sansone, 1990). Given the difficulty in making distinctions between these states that can appear very similar, many ethical questions regarding how to assess and treat individuals with BPD arise.

Prevalence of Borderline Personality Disorder and Rate of Self-injurious Behavior

According to multiple sources, Borderline Personality Disorder affects 2% of the population (APA, 2000; BPD Central, 2001; Fleener, n.d.). It is diagnosed in females 75% of the time (Fleener, n.d.). Despite the small population, BPD represents 20% of inpatients in mental health facilities and 11% in outpatient facilities (Fleener, n.d. and BPD Central, 2001). In a study conducted over a one year time frame, Bongar and others

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found that 12% of all psychiatric ER visits during the year were by people with BPD (Links, Gould, Ratnayake, 2003). According to a study done in Maryland in 1998, the average length of stay for any primary psychiatric diagnosis in the hospital was 6.1 days which incurred an average cost of $5,034 to $5,055 (Brown, 2001, Results section, ¶ 1). Repetitive use of hospitalization for treatment of BPD can result in an incredible cost on insurance companies, tax payers and individuals.

Suicide is the 13th leading cause of death worldwide according to the 2004 World Health Organization report. According to McMain (2007), 57% of people who committed suicide had an Axis II diagnosis. Pompili, Girardi, Ruberto, Tatarelli (2005) report that 9-33% of all suicides are by individuals diagnosed with BPD. Both Fleener (n.d.) and BPD Central (2001) report that 8-10% of all people with BPD will end up committing suicide. These numbers are alarming when considering the best way to treat suicidality in BPD.

In addition, there is a large degree of self-injury in individuals with BPD that does not result in suicide. According to Fleener (n.d.), "sixty-nine to seventy-five percent exhibit self-destructive behaviors such as self-mutilation, chemical dependency, eating disorders and suicide attempts" (p. 1) Self-injury can also be a predictor of who may be at higher risk of suicide. "Successful suicide rates doubles with a history of self-destructive behaviors and suicide attempts" (Fleener, n.d., p.1).

There are also many characteristics that cause BPD to be more complex to treat than other disorders. It is uncommon to find someone diagnosed with BPD without another diagnosis (a dual diagnosis). According to Fleener (n.d.), half of people with BPD have Major Depressive Disorder (MDD) and a quarter have Post Traumatic Stress

Disorder (PTSD). Pompili, Girardi, Ruberto, & Tatarelli (2005) report in their meta-analysis that a "major depressive episode has been associated with an increased mortality rate in some, but not all studies of suicidal behavior in BPD." Pompili, Girardi, Ruberto, and Tatarelli (2005) also found a major depressive episode to be "associated with an increase in the seriousness and frequency of suicide attempts among inpatients with BPD" (p. 319).

There is much speculation as to whether abuse contributes to the development of BPD as well. A history of abuse appears to be commonly found in people with BPD. Fleener (n.d.) reports that 40%-71% of people with BPD report sexual abuse in their past. Links, Gould and Ratnayake (2003) reported on Soloff and others' finding that "in persons with BPD, the history of childhood sexual abuse increases tenfold the risk of suicidal behavior compared with patients without such a history" (p. 306-307). Dubo and others found that with an increased rate of parental sexual abuse , there was a higher incidence and longer duration of self-mutilation and suicidal behavior (Links, Gould & Ratnayake, 2003).

There are many other important facts to consider regarding BPD. Approximately 50% will stop taking their meds at some point during treatment (Fleener, n.d.). Fleener (n.d.) also reports that "22%-35% of domestic violent perpetrators meet the criteria" for BPD. There is a high incidence of substance abuse with BPD and this is associated with a higher incidence of suicidality and self-injury (Links, Gould & Ratnayake, 2003). Altogether, people with BPD have more significant life events such as incest, abuse, losses etc. (Links, Gould & Ratnayake, 2003).

There are many agreed upon risk factors for completed suicide with some slight

variance. Past attempts, higher levels of education, recurrent suicidal behaviors, impulsivity, substance abuse and hopelessness are strong predictors of completed suicide (Pompili, Girardi, Ruberto & Tatarelli, 2005). Runeson and Beskow add that parental abuse, unstable employment (consisting of more than two recent job changes), financial problems lack of permanent residence, sentence by court of law, parental substance abuse (Links, Gould & Ratnayake, 2003).

Lastly, many researchers in the field document that people with BPD can demonstrate either chronic suicidality or an acute-on-chronic risk for suicide. Understanding the risk factors and each client's history and current mental status can assist clinicians in making the proper determination between the two. This will ultimately affect how clinicians will choose to treat the suicidal risk.

Ethical and Legal Requirements in Handling Self-injurious or Suicidal Behavior

The main ethical considerations in working with individuals with BPD and suicidal behavior are beneficence, nonmaleficence, autonomy, informed consent and treating within one's area of competence. Psychiatrists, psychologists, counselors and social workers all have different codes of ethics they are required to follow.

Psychiatrists follow the ethical codes of the American Psychiatric Association. Psychologists and counselors, depending on their particular specialty follow the American Psychological Association, the American Counseling Association (ACA) or the American Association of Marriage and Family Therapists (AAMFT), or some combination of these. Lastly, social workers adhere to the National Association of Social Workers' (NASW) ethical codes.

All ethical codes strongly emphasize beneficence and nonmaleficence. "Psychologists strive to benefit those with whom they work and take care to do no harm" (American Psychological Association, 2002, General Principles Section ¶ 2). They are to defend the well-being and rights of clients as well as minimize harm if some amount of harm has to occur (American Psychological Association, 2002). The ACA (2005) Code of Ethics is very similar, stating that the primary function of a counselor is to promote clients' wellbeing. The AAMFT (2001) states that a therapist "should continue therapeutic relationships only so long as it is reasonably clear that clients are benefiting from the relationship" (Responsibility to Clients, Principle 1.9). They also discuss the therapist's commitment to refrain from abandoning or neglecting clients with the provision that alternative arrangements benefitting the client are made (AAMFT, 2001). The NASW (2008) states that the "primary goal is to help people in need and to address social problems" as well as to "elevate service to others above self interest" (Ethical Principles Section ¶ 2). In summary, practitioners are to make decisions that will promote the overall wellbeing of their client.

In addition to ensuring the wellbeing of clients, practitioners are to promote autonomy. The AAMFT (2001) states that therapists "respect the rights of clients to make decisions and help them to understand the consequences of these decisions" (Responsibility to Clients section ¶ 9). The NASW (2008) directly states that "social workers respect the inherent dignity and worth of the person" (Ethical Principles section ¶ 4). They further elaborate on the duty "to enhance clients' capacity and opportunity to change and to address their own needs" (NASW, 2008, Ethical Principles section ¶ 4). Along with the duty of practitioners to help clients become stable, comes the duty to

assist clients in gaining the ability to maintain stability autonomously. Fine and Sansone (1990) also comment that it is an ethical duty of practitioners to "treat in least restrictive environment" (p. 169). Herein lays the question about repeated hospitalization for the treatment of chronic suicidality in BPD.

While increasing the immediate safety of the client, the client may remain stagnant in his/her ability to learn how to handle feeling suicidal. Therapy is continually interrupted and the client gains no experience learning how to manage the suicidal feeling successfully. While the American Psychological Association (2002) notes that practitioners are to respect individuals' dignity and rights, there are times when "special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making" (General Principles section ¶ 6). The NASW (2008) states similarly that "social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others" (Ethical Standards section ¶ 4). The American Psychiatric Association (2001) speaks in depth about juggling the autonomy and safety of clients when it comes to hospitalization. First, two requirements must be met for involuntary hospitalization. They are a) a mental disorder that incapacitates the person's ability to make sound decisions and b) the risk of harm to one's self or others.

The American Psychiatric Association (2001) goes on to provide both viewpoints regarding autonomy when considering involuntary hospitalization. "Temporary deprivation of physical liberty is justified by the eventual good of returned health" (American Psychiatric Association, 2001, p 28). The idea is that hospitalization will

result in an increase in autonomy of the person. They also cite the principle of beneficence in that practitioners have a right to care for people who are incapable of it independently. The opposing viewpoint is that "liberty is such an important value to society that it transcends all other values" (American Psychiatric Association, 2001, p 28). They propose that as long as an individual poses no threat to other members of the community, autonomy cannot be suppressed. A person's wellbeing is not criteria enough. The American Psychiatric Association (2001) also points out that various states have different laws but there is a common theme. "State legislatures appear to be moving toward a middle ground that meets the treatment needs of the severely mentally ill, while at the same time preserving their legal rights" (American Psychiatric Association, 2001, p 30). Lastly, they reference the "principle of *parens patriae*... regarding the patient, the individual who cannot protect herself; that is, government is responsible for the care of a disabled citizen as loyally as a parent would care for a child" (American Psychiatric Association, 2001, p 30).

Informed consent is meant to benefit the client by increasing his/her awareness of what to expect in treatment and to give the client the autonomy to decide if he/she wants to participate. The AAMFT (2001) states that therapists are to "clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party and the limits of confidentiality" (Responsibility to Clients section ¶ 14). The American Psychological Association (2002) includes that the course of therapy should be discussed and clients should have time to ask questions. If a practitioner is going to utilize a technique that has not been well established, they must discuss this with the client and make them aware of the risks and present alternative techniques or services (American

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Psychological Association, 2002). The NASW (2008) also emphasizes the duty of social workers to use language that the individual can easily understand and should identify any risks involved in using the treatment. It should also be made clear that clients can withdraw from therapy at any time (NASW, 2008).

As much as informed consent is meant to empower the client, it can be a tool for practitioners as well. It can allow practitioners to set up parameters by which they are willing to agree to treat someone with BPD. Fine and Sansone (1990) have suggested a very specific policy regarding suicidal behavior and self-injury in the informed consent. They recommend that right at the start, that practitioners state openly how incidences of self-injury and suicidality will be handled. Thus, the client is given the option to agree to it or to seek services elsewhere. In the end, it benefits both client and practitioner.

Another ethical concern is about competency. The American Psychological Association (2002) states that "psychologists provide services...with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study or professional experience" (Competence section, ¶ 1). The NASW's (2008) policy is extremely similar. If practitioners are not competent to treat an individual, it is their ethical duty to make an appropriate referral and/or assist clients with finding alternative resources for treatment (American Psychological Association, 2002; AAMFT, 2001). The ACA (2005) further requires that counselors "consult with other professionals when they are unsure of their ethical obligations" (Section C.2.e.). The NASW (2008) requires that social workers complete study, training, consultation and supervision by those who are already considered competent before using techniques which are new to them. It would be best practice for

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those with BPD to go to practitioners who specialize in treating BPD. However, often this is not the case. Due to the frequency with which individuals with BPD can bounce between practitioners, how easily BPD can go misdiagnosed to untrained eyes and due to insurance reasons, specialists may not be readily available to someone with BPD. In addition, if a practitioner who is not trained in treating chronic suicidality is presented with the situation, he/she cannot put the issue of suicidality on hold until a better trained professional can intervene. Instead, he/she must intervene until safety is ensured and then look to refer. This presents an ethical question as to whether the hospital would be the more ethical alternative since competency to worth through the suicidality in treatment is in question. Another concern would be the frequency in which this type of situation would occur and what detriment it would have on the client with BPD.

In addition, due to the increased volume of lawsuits and malpractice, practitioners have to be aware of these ethical obligations to the client (short-term safety issues versus long-term therapy progress) while handling their own concern about the potential of losing a client and/or having a lawsuit raised against them. Halleck, as reported in Fine and Sansone (1990) suggests that "because of the potential malpractice risk associated with a patient's suicide, psychiatrists tend to be overly cautious and hospitalize patients believed to be suicidal too frequently and for excessive lengths of time" (p 164-165). It is reasonable to think that if practitioners are unsure which alternative would be best for the client at that given time, they are more likely to lean on the side of caution and hospitalize. The current legal and ethical standards "increase the likelihood that clinicians will implement traditional suicide prevention tactics – including breaking confidentiality and involuntarily hospitalizing patients – rather than executing procedures

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more appropriate for chronic suicidal states" (Fine & Sansone, 1990, p. 163-164). This demonstrates the numerous factors that must be considered when making ethical decisions as to how to treat chronic suicidality.

Lastly, there are guidelines for what a practitioner should do if appropriate resources are not available or if there is no determined standard for treatment. For example, if a client with BPD and chronic suicidality does not have the insurance to see someone trained to treat these issues, according to the American Psychological Association (2002), practitioners "with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study" (Competence section ¶ 4). This means that one can study and cite research and utilize techniques as best they can in order to provide some level of treatment rather than on treatment at all. If there is no particular treatment indicated, the NASW (2008) states that if "generally recognized standards do not exist...social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm" (Ethical Standards section ¶ 13). There are treatment for BPD and treatments to reduce self-injury, but many clients have comorbid disorders which these treatments can be contraindicated for. For example, someone with mild mental retardation who also has BPD will most likely struggle with many of the treatment techniques. Someone with Schizophrenia and BPD will also have added difficulties with the techniques. And at this time, there may not be a standard of

treatment for these smaller, more specific populations. Therefore, practitioners must go to the most relevant research and treat in the best way they can.

Treatment of Self-injury and Suicidal Behavior in Borderline Personality Disorder

Multiple methods of treating BPD exist as well as treatments particular to differentiating and treating acute and chronic risks of suicide. First, there are two treatment approaches which have been proven to have efficacy in the treatment of BPD. Second, there are ways to assess between acute and chronic risk of suicide. Lastly, there are many recommendations for how to handle acute and chronic suicide.

Treatments for BPD

The American Psychiatric Association reports that in random, controlled trials, both Dialectical Behavior Therapy (DBT) and Psychodynamic therapy have been found to be effective (American Psychiatric Association, 2001 and Miller, 2006). They have been found to decrease suicide attempts, decrease hospitalization and improve social adjustment (Miller, 2006). McMain (2007) reports that the mentalization component of the two treatment approaches helps to reduce parasuicidal behavior.

Both DBT and Psychodynamic therapy include weekly individual sessions, weekly group sessions and regular meetings between all of the individual's treating professionals (American Psychiatric Association, 2001). Both have shown that treatment takes on average a minimum of one year (American Psychiatric Association, 2001). They also both stress the importance of the therapeutic alliance as integral to success in therapy (American Psychiatric Association, 2001). This requires practitioners to be mindful of transference and countertransference issues and seek supervision regularly. It

has been found that strong boundaries and limits be maintained as well as maintaining

regular appointments and participation in these meetings (American Psychiatric

Association, 2001).

Dialectical Behavior Therapy (DBT) was designed by Marsha Linehan of the

University of Washington in Seattle. The philosophy in DBT is to "balance recognition

that the feelings...are legitimate and acceptable with insistence that they assume more

responsibility for the effects of their behavior" (Miller, 2006, p. 4-5). In addition to the

three components DBT shares with Psychodynamic therapy, DBT also employs the use

of phone calls to the therapist in an effort to get support in applying newly acquired skills

or to mend what the client perceives as a damaged relationship with the therapist (Kiehn

& Swales, 2004). There are strict guidelines in regards using the phone around episodes

of self-injury; it is permitted in order to prevent self-injury but not allowed up to twenty-

four hours after self-injury (in order to reduce reinforcement of self-injury) (Kiehn &

Swales, 2004). The skills that are taught to the individuals with BPD are core

mindfulness skills, interpersonal effectiveness skills, emotion modulation skills and

distress tolerance skills (Kiehn & Swales, 2004). Clients are taught to "solve their

problems without suicide threats and temper outbursts" and "how to recognize situations

that provoke these reactions and avoid either the situations or the reactions" (Miller,

2006, p. 5). The goals of treatment are arranged in a hierarchy: "1) Decreasing suicidal

behavior 2) Decreasing therapy interfering behaviors 3) Decreasing behaviors that

interfere with the quality of life 4) Increasing behavioral skills 5) Decreasing behaviors

related to post-traumatic stress 6) Improving self-esteem 7) Individual targets negotiated

with the patient" (Kiehn & Swales, 2004, Stages of Therapy section ¶ 8). The main types

of techniques used to help clients reach these goals include validation and problem solving (Kiehn & Swales, 2004). The American Psychiatric Association (2001) also points out that therapy must stay in the here and now and help clients recognize that while they were not to blame for past traumas; they are responsible for learning how to control themselves in the present. More specifically, contingency management, cognitive therapy, exposure techniques and medications are used to facilitate attainment of goals (Kiehn & Swales, 2004). According to the WHO Report, one study found that DBT was better than standard treatment in reducing the repetition of self-injury (Guo and Harstall, 2004).

Psychodynamic therapy involves a similar hierarchy of goals in the treatment of BPD. There is more emphasis put on the interpretation part of the therapy. In this type of treatment, practitioners are "making the unconscious conscious by linking a feeling, thought or symptom to an unconscious meaning derived from early experience" (Miller, 2006, p. 4). Miller (2006) also describes the intent to "free patients from unacknowledged motives or wishes that interfere with the ability to satisfy their needs" (p. 4). This can be done by identifying and challenging defense mechanisms, examining transference issues and linking past experiences to present experiences (Miller, 2006).

Other treatments that have been tried with BPD are Cognitive Behavioral Therapy (CBT), short-term Interpersonal therapy, Outpatient Group Therapy, Psychopharmacology, Family therapy and Couples therapy. None have been tested and proven to be effective as DBT and Psychodynamic therapy have at this time.

Guo and Harstall (2004) report on van der Sande et al.'s meta-analysis that "each of the four studies on CBT demonstrated small benefits that were significant in the

pooled analysis..." (p. 10). In CBT, practitioners attempt to help clients reframe "unconscious self-defeating assumptions" such as "the world is dangerous and malevolent, I am powerless and vulnerable, and I am inherently unacceptable to others" (Miller, 2006, p. 4). According to Wilberg, Friis, Karterud, Mehlum, Urnes and Vaglum (1998), short-term interpersonal therapy combined with CBT via group and individual sessions has been shown to be effective in two randomized studies. The addition of outpatient group therapy to day treatment was found to be better than day treatment alone in a three year study (Wilberg et al, 1998). Miller (2006) also recommends that family and couples therapy can be helpful but they recognize that both have specific limitations when working with BPD. The American Psychiatric Association (2001) suggests that group therapy, family therapy and couples therapy be used as adjunctive therapy and are not sufficient independently. At times, couples therapy can be more harmful if it is the sole treatment modality (American Psychiatric Association, 2001). Group therapy can be helpful in that it increases hope, provides a sense of universality, and "allows patients to express feelings and tolerate criticism they not accept from an authority figure" (Miller, 2006, p. 4). Lastly, psychopharmacology has been found to be helpful to "treat state symptoms during periods of acute decompensation as well as trait vulnerabilities" (American Psychiatric Association, 2001, Section II. D. 2. ¶ 1). There has been no evidence showing that medications alone can be an effective treatment for BPD (Barnett, 2008). Medications can be particularly helpful in treating impulse control, regulation of emotion, symptoms of corresponding Axis I disorders, and cognitive-perceptual difficulties (American Psychiatric Association, 2001). The most common medications that are used are antidepressants for anger and depression, Lithium and anticonvulsants as

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mood stabilizers, benzodiazepines for anxiety and antipsychotics for distorted thinking (Miller, 2006).

Recommendations for Treating Acute and Chronic Suicidal Risks

The main aim of this research was to determine that acute and chronic risks of suicide must be treated in very different ways. To treat them in the same way can be counter-therapeutic or worse, fatal. The first step is distinguishing the different level of risk and secondly deciding the best mode of treatment. There are many options recommended by various professionals but there are distinct and separate goals for treating acute risk and for chronic risk.

Many assessments have been developed to assist clinicians in assessing suicidality. Aaron Beck developed the Beck Depression Inventory (BDI) and the Beck Hopelessness Scale (BHS) which are good indicators of level of risk in acute suicide. Barnett (2008) also recommends use of the Brief Symptom Inventory, the Outcome Questionnaire-45 and the Suicide Status Form for acute suicide. For chronic suicide, Linehan developed the Parasuicide History Interview (PHI) and the Lifetime Parasuicide Count (LPC). She also developed an assessment for BPD called the Borderline Symptom List 23 (BSL 23) that includes a supplement that documents frequency of parasuicidal behavior in the last week. In addition to using objective assessments, the importance of taking a complete history from the client or reviewing past records is understood as an integral first step. This includes a detailed history of any previous attempts at suicide or any past self-injury (Barnett, 2008; Fine & Sansone, 1990).

Acute risk of suicide is often managed first by an extensive assessment including a broad history, consideration of demographics (that correlate with risk factors), the

current mental status, the specificity of plan and the availability to the means as well as the level of commitment to the plan. (Fine & Sansone, 1990). The next step is to explore in therapy the circumstances around the suicidal ideation and attempt to help the client to resolve the issue and reassess (Fine & Sansone, 1990). If there is still a risk, the practitioner should attempt to get the client to voluntarily admit himself/herself to the hospital (Fine & Sansone, 1990). If the client refuses and there is still an imminent risk, the practitioner must bypass confidentiality and autonomy and ensure safety via involuntarily hospitalizing the client (Fine & Sansone, 1990).

One of the concerns that this research attempts to address is whether or not methods for treating acute suicide risks are being overused to treat chronic suicide risk. It may be due to fear of liability, lack of knowledge on the part of the practitioner or other reasons. Fine and Sansone (1990) note the level of responsibility that has been placed on practitioners to prevent suicide over the last few years. They believe the effect of this has been that "psychiatrists tend to be overly cautious and hospitalize patients believed to be suicidal too frequently and for excessive lengths of time" (Fine & Sansone, 1990, p. 165). Jobes, as stated in Barnett (2008), suggests that "many therapeutic intervention strategies are not adequately designed to help the suicidal client and simply rely on short-term hospitalization, psychotropic medications and a no-suicide contract" (p. 410). Another disadvantage of recurrent utilization of the hospital is that it very expensive and most likely not cost efficient. Practitioners should consider whether it their responsibility to take this factor into consideration. There is much disagreement in the mental health field about the effectiveness of safety contracts in regards to its amount of assistance to the client and prevention of lawsuits against the practitioner. "In malpractice litigation,

safety contracts may actually work against the clinician's defense" (Barnett, 2008, p. 407). Barnett (2008) suggests establishing a plan early on with the client that includes coping skills and a plan for obtaining professional help if the coping skills are unsuccessful.

"Traditional therapeutic maneuvers may actually reinforce their destructive interpersonal dynamics as well as divert attention away from critically important therapeutic issues" (Fine & Sansone, 1990, p. 163). Thus, chronic suicidality must be treated in a different way to address the different underlying causes. Fine and Sansone (1990) first suggest making a mutually agreed upon contract at the start of therapy. It should set limits on self-injurious by outlining consequences such as termination of therapy and an explanation that no extra parameters will be taken to protect the client as this would simply reinforce the pattern of self-injury (Fine and Sansone, 1990). The practitioner should state his/her ethical and legal requirements and emphasize that it is the duty of the practitioner and not a sign of the practitioner's own feelings about the client (Fine and Sansone, 1990). It should be explained and documented that there is a difference between acute and chronic risks (Fine and Sansone, 1990). Barnett (2008) suggests that the next step would be to create a mutually agreed up plan for how the client will cope in times of feeling suicidal.

Kernberg (1993) also has a set of guidelines that should be established at the start of treatment. He requires that suicidal intentions be discussed in session, in the here and now and interpreted. However, if it occurs between sessions, the client should proceed to the hospital. Kernberg (1993) states that it is imperative that the practitioner refrain from any type of rescue if the client is hospitalized and he/she should instruct the family to do

so as well in order to reduce reinforcement. When treatment is resumed, the practitioner should "explore and resolve interpretatively the dissociation between what goes on inside and outside the treatment hours" (Kernberg, 1993, p. 252). The episodes of self-harm have to be incorporated into the client's narrative (Kernberg, 1993). Kernberg (1993) suggests that the clinician act as a "holding function" where the client can "transform self-destructive behavior directed against the patient's own body...into psychic experience played out in the transference" (p. 253).

Throughout treatment, the practitioner should explore the need that resorting to chronic suicidal behavior fulfills (Fine & Sansone, 1990). Responsibility for actions must constantly be put in the hands of the client. Gunderson describes that often the suicidal behavior can be an attempt to get the attention of other people (Fine & Sansone, 1990). The appropriate response is not to ignore or rescue but to process and interpret the meaning of the behavior and discuss more appropriate methods of getting the need met (Fine & Sansone, 1990). At times, the gestures may be an attempt to indirectly ask for something and thus, the gesture should be processed first (Fine & Sansone, 1990). The practitioner has a responsibility to help the client evaluate how adaptive the behavior is and brainstorm alternatives. If hospitalization is required, it is recommended that the practitioner state that he/she is opposed to it and explain that the circumstances render the practitioner's efforts ineffective. Gunderson further states in Fine and Sansone (1990) that "if patients wish to test whether others care for them, it cannot be learned by eliciting preventative responses to their self-destructiveness" (p. 167). Again, it should be emphasized that the practitioner is responding based on the requirements of his/her job, not out of personal feeling (Fine & Sansone, 1990).

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Krawitz et al. (2004) describe "professionally indicated short-term risk taking" to refer to the management of chronic suicide (p. 12). They define it as a "solid and thorough decision-making process in which risk assessment considers the balance of short-term and long-term risk and leans in the direction of increasing short-term risk in order to minimize overall risk" (Krawitz et al., 2004, p. 12). Krawitz et al. (2004) suggests that treatments used for acute risk actually cause regression and dependency in people with chronic suicidality. It is suggested instead that the practitioner and client "collaboratively explore what the client may do about their distress" in order to create "a balance between creating an environment that protects against suicide in the short term and an environment that promotes change, and thereby protects against suicide, in the long run" (Krawitz et al., 2004, p. 12). Episodes of suicidal crisis are the opportunities for clients to practice skills such as distress tolerance, emotional regulation or other alternatives to suicide. To take this opportunity away via hospitalization can hinder learning and growth. Hence, a balance between safety and learning must be obtained. According to Jackson W., a client once stated, "I have learnt to access services by being at risk and you reinforce this if you over-respond" (Krawitz et al., 2004, p. 13). Jackson W. also shared a client's comment that the "hospital became a place which was too safe; where I took no responsibility for myself and had no need to take control of my life" (Krawitz et al., 2004, p. 13). Krawitz et al. (2004) warn that this type of treatment approach is only appropriate for someone with chronic suicidality and not for someone with another severe mental illness. It must be agreed upon by all the treatment providers and must have included a detailed history that shows a pattern of chronic suicidal

behavior (Krawitz et al., 2004). There must already be a rapport established with the client and a guideline for crisis in place.

Specific Research Questions and Hypotheses

Overall, the goal of the study is to better understand what type of treatment is most ethical for treating chronic suicidality and parasuicidality in individuals with BPD. Multiple factors must be considered including the immediate safety of clients, the best long-term treatment, differentiating acute versus chronic risks, legality issues, competency and autonomy of the client. This study is questioning the different views on the treatments for treating chronic suicidality in BPD based on the type of occupation within the mental health field and the type of organization worked for, the different levels of training and years of experience and the different treatment modalities.

H1: Beliefs about what is considered ethical in the treatment of chronic suicidality in clients with BPD will differ based on the type of occupation, or title, one has within the mental health field.

H2: Beliefs about what is considered ethical in the treatment of chronic suicidality in clients with BPD will differ based on the type of organization or agency the practitioner works at.

H3: Beliefs about what is considered ethical in the treatment of chronic suicidality in clients with BPD will differ based on the type of treatment modality the practitioner uses.

H4: Beliefs about what is considered ethical in the treatment of chronic suicidality in clients with BPD will differ based on the number of years the practitioner has worked with clients with mental health diagnoses.

H5: Beliefs about what is considered ethical in the treatment of chronic suicidality in clients with BPD will differ based on the highest level of schooling the practitioner has completed.

CHAPTER II

Method

Participants

There were a total of 63 participants in the study with 32% males and 64% females. All participants were professionals in the mental health field in New Jersey and Pennsylvania. Professions mainly included: psychiatrists, psychologists, counselors and social workers. The participants ranged in age from 20 to over 60. A majority of participants worked in private practice (68%) and 19% worked in a non-profit agency. The average age of participants was between 41 and 50 years. A majority of the participants had a Doctoral degree (43%). Forty percent had a Graduate degree, 11% had an Undergraduate degree and less than 2% had an Associate's degree. Participants had worked in the field for as little as less than one year to as much as over 40 years. The average number of years worked in the mental health field was somewhere in the category of 20 to 29 years. Of these years, the average number of years worked with Borderline Personality Disorder was 19 years. Participants were selected using a convenience sample from local phonebooks and internet search engines for the area.

Instrumentation

    Materials

    Demographic Questionnaire. Participants were asked to give their age, sex, highest level of completed schooling, title of occupation, type of organization they work

for, their treatment modality, number of years working in the mental health field and their number of years working with BPD.

Survey. A survey was created to give scenarios that present ethical questions for the participant to respond to. Six scenarios were created describing a case with someone with BPD or another mental illness that was experiencing suicidality. The various scenarios depicted people with an acute risk of suicide, a chronic risk of suicide or an acute on chronic risk of suicide. The scenarios also had multiple other variables included such as dual diagnoses, status of personal relationships, living situations, access to means of suicide, etc. After each scenario were five possible ways to respond to the situation. With each response was a Likert Scale that gave varying levels of agreement or disagreement: Strongly Agree, Somewhat Agree, Somewhat Disagree or Strongly Disagree. They were asked to identify one of these four choices as to how much they agreed/disagreed with each of the responses to all six scenarios (see Appendix).

Secondly, participants were asked to rank the five possible ways to respond for each question. They were to assign numbers 1-5 with 1 = First Choice of Response and 5 = Last Choice of Response to Options A – E (see Appendix). This would demonstrate what response the clinician would most likely use in each scenario.

Last, they were asked to read ten statements on various ethical concerns. Again the Likert Scale was used with the four levels of agreement/disagreement. They were asked to identify their level of agreement/disagreement by circling the appropriate choice after reading each statement. Statements included topics on issues such as competency, autonomy, beneficence, treatment choices etc. An example of one of the statements was: "To involuntarily commit someone to the hospital psychiatrically is impeding on their

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rights and does not promote autonomy" (see Appendix B). Another example was: "If a client signs a safety contract and then breaks it and commits suicide; the clinician should not be held liable" (see Appendix B).

Design

This study utilized a quasi-experimental design and survey methodology. The independent (predictor) variables were title, type of organization, treatment modality, years of experience in the mental health field and level of training. The dependent (criterion) variables were beliefs about ethical practice and ways of treating chronic self-injury and suicidal behavior in people with BPD as represented by the answers to the scenarios, rankings and statements.

Procedure

Organizations and individuals were mailed an informed consent (see Appendix A), a summary of the intentions of the study and a copy of the demographics questionnaire and survey (see Appendix B) and were asked that if needed; to provide approval for their organization to participate in the study via typed letterhead. Once they agreed to participate, they were asked to return the demographics questionnaire and survey. They were asked to complete the surveys independently and return them via an enclosed prepaid postage envelope. The questionnaires took approximately 10-12 minutes to complete. This study was approved by the university's Institutional Review Board and the procedures conformed to the ethical codes of the American Psychological Association.

CHAPTER III

Results

Of the 372 surveys that were mailed to mental health professionals, 63 surveys

(17%) were completed and returned. The first part of the survey asked about the

demographics of the population. The first goal of the study was to determine the sex and

age of the participants as well as their professional title (counselor, psychiatrist etc), what

type of organization they worked for (private practice, non-profit), their type of degree

(Doctorate, Graduate etc), what type of modality they practice (Cognitive Behavioral,

Psychoanalysis etc) and how many years of experience they had. There were more

female (64%) than male (32%) participants. One percent of participants did not give

their sex. The age of participants ranged from 20 years old to over 60 years old, with a

majority of participants being older than 50 years. Six percent were ages 20-30, 19%

were ages 31-40, 17% were ages 41-50, 27% were ages 51-60 and 25% were over the age

of 60. Most participants had either a Graduate degree (40%) or a Doctoral degree (43%).

Less than 2% of participants had an Associate's degree and 11% had an Undergraduate

degree. Most participants worked in a private practice (68%) and 19% worked in a non-

profit agency. Less than 2% worked in a state facility and 6% worked in a completely

different type of setting which was not specified. No participants worked in an inpatient

setting and three participants did not answer the questions about age, degree or

organization. Thirteen percent of participants were psychiatrists, 30% were counselors,

29% were psychologists, 16% were social workers and 8% did not fall into any of these

categories. Some examples of other titles were spiritual counselor and nurse practitioner. The range of years of experience working in the mental health field was less than one year to 40 years or more. Most participants had 20-29 of experience (37%) or 10-19 years of experience (21%). Only 2% had less than one year of experience and 6% had 40 or more years of experience. Number of years of experience working with Borderline Personality Disorder was not used as a factor because it was frequently the same as years of experience in the mental health field. A majority of the questions were answered on the surveys. However, approximately 3.5% did not give responses on the Scenario questions, 6% did not respond to the rankings and 1% did not respond to the statements.

The second goal of the study was to examine the relationship between the demographic variables and the responses to the questions. A repeated measures analysis was used to determine if there was a difference in how participants answered the six scenario questions. The following are the choices that followed the scenarios: Choices A-E.

A) Explore her thoughts about suicide and discuss what is causing her to feel this way and attempt to resolve the suicidality through therapy because safety contracts are not effective.

B) Explore her thoughts about suicide and discuss what is causing her to feel this way and attempt to resolve the suicidality through therapy because safety contracts are not effective. You increase the parameters to ensure safety by scheduling extra sessions and giving her a number to reach you at outside office hours.

C) You explore her thoughts about it and fill out a safety contract with her which she agrees to. You include coping skills she can use and identify people she can go to for

support. You give her a number she can reach if she feels she cannot abide by the contract.

D) You explore her thoughts about it with her and then recommend she be seen by Screening to assess her for safety. You call screening and have them assess her.

E) You explore her thoughts about it with her and call 911. You have the ambulance come out and recommend that she be directly admitted to the hospital.

A Likert Scale was used to measure level of agreement/disagreement: 1= Strongly Agree, 2=Somewhat Agree, 3=Somewhat Disagree, 4=Strongly Disagree. The following is a brief description of the six scenarios;

1)   A client with Major Depressive Disorder, Recurrent type and a history of suicide attempts reports increased depression and thoughts of suicide and has thought about taking the pills she has at home.

2)   A client with BPD and depressive episodes with a history of suicide attempts and self-injury comes into session stating that she feels suicidal because her mom is too busy, her dad isn't helping out and her sister has a cold.

3)   A client with BPD who was recently discharged from the hospital for suicidality expresses suicidal thoughts, stating she wants to kill herself so she can be with her father when he finally passes away from his terminal illness. She has a plan to go to the store and buy two bottles of Tylenol to take.

4)	A client with BPD and Mild Mental Retardation with a history of hospitalizations

for suicidality and poor communication skills reports feeling suicidal and requests to go

to the hospital because she is unhappy that her family is asking her to get a part time job.

5)	A new client who has never been in mental health treatment recently dropped out

of college and reports feeling hopeless and doesn't want to live anymore. She has

considered cutting her wrists.

6)	A client with BPD is being kicked out of her living situation, is revoking consent

for family members, is angry at her friends and feels betrayed by her family and reports

feeling suicidal and says she will take a bottle of pills tonight if her friend is not home.

She has a history of unstable housing and switches therapists frequently.

First, Choice A was examined for each of the six scenarios to see if there was a

significant difference in how much participants agreed/disagreed with using this choice in

response to the various scenarios. Secondly, each variable was looked at individually to

see if there was a significant difference in the way they answered. Lastly, Choice A was

examined with one demographic variable, such as type of degree, to see if participants

with different degrees had significantly different answers. Both within-subjects and

between-subjects comparisons were used. The same was done for Choices B-E as well,

utilizing all the various demographic variables.

Participants answered very differently in their level of agreement/disagreement

for the five choices of the scenarios. There was a statistically significant difference in the

way participants answered for Choice A of the scenarios $F(5,205)=6.470, p=<.001$.

Choice A suggested maintaining sessions without utilizing a safety contract or any other

extra parameters. The overall mean answer was 2.8, which averages between Somewhat

Agree and Somewhat Disagree. The following are the means for Choice A for each

scenario: Scenario 1: 2.7, Scenario 2: 2.5, Scenario 3: 3.2, Scenario 4: 2.8, Scenario 5:

2.6, Scenario 6: 3.0. There were statistically significant differences in the responses to

particular scenarios, particularly Scenario 3 and 6. Scenario 3 had a statistically

significant difference from Scenario 1, 2, 5 and 6 (p=<.001) and from Scenario 4

(p=.003). Scenario 6 also had a statistically significant difference from Scenario 2

(p=.009). Participants were more likely to disagree with Choice A for Scenarios 3 and 6.

There was a statistical significance for sex of the participant, $F(1,39)$=5.127, p=.029 and

title of the participant, $F(4,41)$=3.141, p=.024. Males' overall response was Somewhat

Agree (M=2.3) while females' was Somewhat Disagree (M=3.1) which was statistically

significant (p=.004). Psychiatrists' overall response was Somewhat Disagree (M=3.0),

counselors' was similar (M=3.1), psychologists' was 2.6, social workers' was 3.1 and

those in the "other" group was 2.0. The "other" group's responses were statistically

significantly different from counselors, p=.017 and social workers, p=.012.

Many variables had an effect on the outcome of the choices such as sex of the

participant, type of organization, and the degree of the participant for Choice A. The sex

of the participant resulted in a statistically significant difference in how Choice A was

rated $F(5,195)$=3.846, p=.002 . Males chose Somewhat Disagree (M=2.0) for Scenario 1

and 2 while females chose Somewhat Agree (M=3.0) for both. The type of organization

that participants worked for also had an effect on how participants answered

$F(15,220)$=1.894, p=.025. Participants who worked in private practice and non-profit

organizations answered very similarly compared to those who fell into the "other"

category. Those in the "other" category answered Strongly Disagree (M=4.0) for each

Scenario, except Scenario 5, in which they answered Somewhat Agree (M=2.0). Those

in the private practice and non-profit agencies chose Somewhat Agree (M=2.5) for

Scenario 1 and 2 and Somewhat Disagree (M=3.0) for Scenario 3, 4, 5 and 6. Lastly, the

type of degree the participants had, affected their choices $F(10,185)$= 2.950, p=.002.

Those with Undergraduate degrees and Graduate degrees answered very similarly,

however those with Doctorates answered differently. For Scenarios 1, 2 and 5, those

with Doctorates answered Somewhat Agree (M=2.0) whereas those with Graduate and

Undergraduate degrees answered Somewhat Disagree (M=3.0). On the remaining

scenarios, they all chose Somewhat Disagree.

Choice B showed a statistically significant difference across the multiple

scenarios $F(5,205)$=2.539, p=.030. The mean response to Choice B was 2.7 which

averages between Somewhat Agree and Somewhat Disagree. Choice B suggested adding

extra sessions and providing an on-call phone number for the client. The following are

the overall means for Choice B for each of the Scenarios: Scenario 1: 2.5, Scenario 2: 2.6,

Scenario 3: 3.0, Scenario 4: 2.7, Scenario 5: 2.5 and Scenario 6: 2.9. Again, Scenarios 3

and 6 showed a statistically significant difference in the way Choice B was rated

compared to the other scenarios. Scenario 3 was different from Scenario 1 (p=.015),

Scenario 2 (p=.013), Scenario 4 (p=.001), Scenario 5 (p=.032). Scenario 6 was

statistically significantly different from Scenario 1 (p=.025) and Scenario 5 (p=.008).

The participants chose Somewhat Disagree more frequently for these two scenarios and

Somewhat Agree with Choice B for the other scenarios. There was a statistical

significance in the way that participants of different degrees, $F(2,37)$=5.172, p=.010 and

organizations, $F(3,38)=3.958, p=.015$ answered. Undergraduates overall response was 3.5 which was statistically significantly different from Graduates, $p=.026$ (M=2.6) and Doctorates, $p=.002$ (M=2.3). Those in private practice had an overall response of 2.4 which was statistically significantly different from those in non-profit organizations, $p=.046$ who chose Somewhat Disagree (M=3.1). Those in the "other" category responded Somewhat Disagree (M=3.0).

Age, sex, organization and years experience did not affect how participants rated Choice B, however, title, modality and degree did. Title was statistically significantly different, $F(20,155)=1.644, p=.049$. Psychiatrists and Social Workers rated Choice B differently for Scenario 1. Psychiatrists more often chose Somewhat Agree (M=1.8) and social workers more often chose Somewhat Disagree (M=3.3). For Scenario 3, all participants were more likely to pick Somewhat Disagree. For Scenario 4, psychiatrists and those in the "other" category picked Somewhat Agree on average (M=2.2) but psychologists more often picked Somewhat Disagree (M=3.2). In response to Scenario 5, psychiatrists chose Somewhat Disagree (M=3.3) with Choice B when psychologists picked Somewhat Agree (M=2.2). For Scenario 6, psychologists and social workers rated Choice B as Somewhat Disagree (M=3.6, M=3.2). Modality appears to have an effect on how participants rated Choice B, $F(30,145)= 1.547, p=.048$. However, this may be due to multiple modalities being under-represented. Psychoanalysis, behavioral, interpersonal and existential modalities each had less than 5 participants in their category. These were the modalities that had significant differences from the Psychodynamic, Cognitive Behavioral and the "other" types of modalities, which often rated Choice B similarly. Participants' degree had bearing on how they rated Choice B $F(10,185)=1.964$,

p=.039. Undergraduates (M=3.3) and Graduates (M=2.9) chose Somewhat Disagree with

Choice B for Scenario 1 whereas those with Doctorates chose Somewhat Agree (M=2.0).

Undergraduates chose Somewhat Disagree for Scenario 2 (M=3.3) and Scenario 3

(M=3.5) while others fell somewhere between Somewhat Agree and Disagree. For

Scenario 4, Undergraduates chose Somewhat Disagree (M=3.3), Graduates chose

Somewhat Agree (M=2.2) and Doctorates answered both. Undergraduates chose

Strongly Disagree (M=4.0) to Choice B for Scenario 4, while Graduates answered

between Somewhat Agree and Disagree (M=2.5) and Doctorate level participants

averaged between Strongly Agree and Somewhat Agree (M=1.6). Lastly, in response to

Scenario 6, Undergraduates answered between Strongly Disagree and Somewhat

Disagree (M=3.7) while Graduate (M=2.6) and Doctoral (M=2.8) level participants

varied between Somewhat Agree and Somewhat Disagree. It appears that title, modality

and degree affect how often participants would try to work through these issues in

therapy with extra parameters.

Choice C showed a statistically significant difference in how participants rated it

overall $F(5,210)=7.297$, *p*=<.001. The overall mean rating for Choice C was 2.1, which

is Somewhat Agree. Choice C recommended the use of a safety contract. The overall

means for the individual scenarios are as follows: Scenario 1: 1.9, Scenario 2: 2.0,

Scenario 3: 2.6, Scenario 4: 1.9, Scenario 5: 1.8, Scenario 6: 2.4. Scenarios 1, 2, 4 and 5

all resulted in a response to Choice B of Strongly Agree to Somewhat Agree. Scenarios 3

and 6 resulted in ratings from Somewhat Agree to Somewhat Disagree. There was a

statistically significant difference between Scenario 3 and Scenarios 1, 2, 5 and 6

(*p*=<.001) and Scenario 3 and 4 (*p*=.003). There was also a statistically significant

difference between Scenario 6 and Scenario 2 ($p=.009$). There was a statistical

significance in the way in which participants of different age, $F(1,32)=2.857, p=.039$,

sex, $F(1,45)=14.576, p=<.001$, degree, $F(2,45)=3.320, p=.045$ and years of experience,

$F(4,39)=3.240, p=.035$, responded to Choice C. Participants who were 40 or younger

had an overall response of 1.7, while those 41 and older had a response of 2.0 to 2.6.

Males' overall response was 2.7 while females' was 1.8 which was statistically

significant, $p=<.001$. Undergraduates, whose average response was 2.8 was statistically

significantly different from Graduates (M=1.9), $p=.015$, and Doctorates (M=2.1), $p=.022$.

Those with less than 20 years of experience had a response of 1.7 to 1.8, while those with

more than 20 years of experience have scores of 2.1 to 2.5.

Degree, $F(10,80)= 2.127, p=.031$ and organization $F(10,195)=2.108, p=.025$

both impacted how participants rated Choice C. Undergraduates most often chose

Somewhat Disagree, Graduates most often chose Somewhat Agree and Doctorates varied

from Strongly Agree to Somewhat Disagree in their responses. Doctorate level

participants chose Strongly Agree for Scenario 4 (M=1.3), Somewhat Agree for Scenario

5 (M=1.9) and Somewhat Disagree for all the other scenarios along with Undergraduates.

Graduate level students rated Choice B the most differently from the other degrees. The

organization that had the most impact on how Choice B was rated was the "other" group.

They were more likely to choose Somewhat Disagree for the first two scenarios (M=3.5,

M=3.0), whereas those in private practice (M=1.6, M=1.8) and non-profit agencies

(M=2.0) chose Somewhat Agree. For the other scenarios, organization had little effect on

the ratings.

Choice D, which was to have the client evaluated by screening, showed a

statistically significant difference in the way it was rated across all the scenarios, $F(5,160)=5.746$, $p=<.001$. The overall mean rating for Choice D was 2.2 which is Somewhat Agree. The following is how Choice D was rated on average for each individual scenario: Scenario 1: 2.4, Scenario 2: 2.4, Scenario 3: 2.0, Scenario 4: 2.5, Scenario 5: 2.1, Scenario 6: 1.8. Scenario 6 had a statistically significant difference from the ratings of Scenario 1 ($p=.007$), Scenario 2 ($p=.006$), Scenario 4 ($p=<.001$). Scenario 3 also had a statistically significant difference from Scenario 1 ($p=.032$), Scenario 2 ($p=.014$), Scenario 4 ($p=.003$). There was a statistical significance in the responses of participants with various degrees, $F(2,39)=7.816$, $p=.001$, as well as between males and females $F(1,42)=9.284$, $p=.004$. There was a statistical significance between Undergraduates' (M=1.3) response and Graduates' (M=2.1), $p=.046$ as well as between Undergraduates and Doctorates' (M=2.5), $p=.002$. There was a statistical significance in the way that males (M=2.7) and females (M=2.0) answered, $p=.006$.

Few demographic variables affected how participants rated Choice D, however modality $F(30,155)=1.586$, $p=.038$, and title $F(20,195)=1.773$, $p=.026$, did. The modalities with a sufficient number of participants were Psychodynamic, Cognitive Behavioral and "other". They varied on their answers for Scenario 2, in that the CBT group averaged between Somewhat Agree and Disagree (M=2.8), whereas the other two answered Somewhat Agree (M=2.2) consistently. For Scenario 4, the CBT group answered Somewhat Disagree (M=3.0) where the psychodynamic group answered Somewhat Agree (M=2.0). In response to Scenario 5, the psychodynamic group averaged between Strongly Agree and Somewhat Agree (M=1.6), while the CBT group varied between Somewhat Agree and Disagree (M=2.4). Psychiatrists and Social

workers most often answered Somewhat Agree to Choice D. The only exception was in Scenario 4, in which psychiatrists chose Somewhat Disagree (M=3.0) more frequently, but all the other participants chose Somewhat Agree. Counselors averaged between Strongly Agree and Somewhat Agree for all scenarios. Psychologists ranged from Strongly Agree to Somewhat Disagree, depending on the scenario. They disagreed only with Scenario 4 and 5 (M=2.9, M=3.1) but Strongly Agreed (M= 1.4) to Choice D in Scenario 3. Psychologists were the only group to choose Somewhat Disagree (M=3.1) for Scenario 5. Those in the "other" category had a range of scores from Somewhat Agree to Somewhat Disagree.

Choice E had a statistically significant difference in how it was rated across the scenarios, $F(5,195)=7.163$, $p=<.001$. Choice E was to call 911/ambulance and have the client admitted to the hospital. The overall mean rating for Choice E was 2.7 which averages between Somewhat Agree and Somewhat Disagree. The means for the ratings of Choice D for each scenario is as follows: Scenario 1: 3.1, Scenario 2: 3.2, Scenario 3: 1.8, Scenario 4: 3.2, Scenario 5: 2.9, Scenario 6: 2.0. Participants agreed with Choice D more frequently for Scenario 3 and 6 and disagreed with Choice D for the other scenarios. Scenarios 3 and 6 had a statistically significant difference from all the scenarios except each other ($p=<.001$). There was a statistically significant difference in how participants of different organization, $F(3,40)=4.680$, $p=.007$, responded as well as between males and females, $F(1,42)=5.522$, $p=.024$. Those in private practice had an overall response of 2.9, while those in non-profit agencies had an overall response of 2.4 and those in the "other" group had an overall response of 1.8. There was a statistical significance between those in the "other" group and the private practice, $p=.007$. Males'

overall response was 3.2 while females' was 2.5, which resulted in a statistical significance of p=.013.

The only demographic variable that appeared to have a statistically significant difference for Choice E was modality, $F(30,170)$=1.555 , p=.043. Those in the Psychodynamic group answered differently than those in the CBT and "other" group in some scenarios. For Scenario 1 and 2, those in the psychodynamic group averaged between Somewhat Disagree and Strongly Disagree (M=3.6, M=3.7) while the CBT and "other" group chose Somewhat Disagree (M=2.8, M=3.0). The psychodynamic group also had a different response to Scenario 4. They averaged between Somewhat Disagree and Strongly Disagree (M=3.8) while those in the CBT and "other" group chose Somewhat Disagree (M=2.8, M=3.0). The psychodynamic group's answers seemed to be stronger than the other groups.

There seems to be a pattern as to the type of response certain groups have when handling cases of suicidality. What appears most evident is that the type of response varies greatly depending on the individual case of suicidality. There are certain factors that cause participants to take different responses. Seeing how participants ranked the choices for each scenario helps to give greater insight into what participants believe to be the best response to each situation.

The third goal of the study was to see how what response participants were most likely and least likely to use. The rankings were done by asking participants to rank Choices A-E for each individual scenario from 1 to 5 designating their favored choice to least favored choice. Choices A-E are as follows;

A) Explore her thoughts about suicide and discuss what is causing her to feel this way

and attempt to resolve the suicidality through therapy because safety contracts are not effective.

B) Explore her thoughts about suicide and discuss what is causing her to feel this way and attempt to resolve the suicidality through therapy because safety contracts are not effective. You increase the parameters to ensure safety by scheduling extra sessions and giving her a number to reach you at outside office hours.

C) You explore her thoughts about it and fill out a safety contract with her which she agrees to. You include coping skills she can use and identify people she can go to for support. You give her a number she can reach if she feels she cannot abide by the contract.

D) You explore her thoughts about it with her and then recommend she be seen by Screening to assess her for safety. You call screening and have them assess her.

E) You explore her thoughts about it with her and call 911. You have the ambulance come out and recommend that she be directly admitted to the hospital.

A repeated measures analysis was used to analyze the rankings for each of the scenarios. The various demographic variables were compared to see if there were any significant differences affecting the order of the rankings. First, the overall rankings of Choices A-E were examined for each individual scenario. Then, the rankings were examined with regard to how the various demographic variables impacted the rankings.

The rankings for Scenario 1 showed a statistical significance, $F(4,156)=6.883$, $p=<.001$. This means that participants ranked the choices differently based on the scenario which is about a client with Major Depressive Disorder who is feeling depressed and thinking about taking all her pills at home. The average order of the rankings for

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Scenario 1 was Choice C, B, D, A, E. The means for these rankings are as follows: Choice C: M=1.9, Choice B: M= 2.7, Choice D: M=2.9, Choice A: M=3.4 and Choice E: M= 4.0. There was a statistically significant difference between the rankings of C and E (p=<.001), C and A (p=<.001), C and D (p=.016), B and E (p=.020) and B and A (p=.001).

Sex, organization, degree and title affected how participants ranked the choices. Males and females ranked the choices very differently $F(4,160)$=6.647, p=<.001. Males ranked the choices: B (M=1.9), A (M=2.1), C (M=2.3), D (M=3.9), E (M=4.8) whereas females ranked the choices C (M=1.5), B (M=2.7), D (M=2.8), A (M=3.8), E (M=4.1). The type of organization the participants worked for also affected how they ranked the choices $F(8,160)$=3.761, p=.001. Those in private practice ranked the choices C (M= 1.7), B (M=2.3), A (M=3.1), D (M=3.4), E (M=4.5) while those in non-profit agencies were more likely to rank the choices D (M= 1.7), C (M=2.2), B (M=3.0), A (M=4.0), E (M=4.1) and those in the "other" group ranked them D and E (M= 1.5), C (M=3.0), A and B (M= 4.5). Degree had a statistical significance for the rankings as well, $F(8,148)$=3.011, p=.004. Undergraduates ranked the choices: C and D (M=1.8), E (M= 3.1), B (M=3.8), A (M=4.6). Graduate level participants ranked the choices: C (M= 1.7), D (M= 2.7), B (M= 2.8), A (M= 3.9), E (M= 4.0). Doctoral level participants ranked the choices: B (M= 1.9), C (M= 2.1), A (M= 2.6), D (M= 3.7), E (M= 4.7). Lastly, the participants' title had bearing on how the choices were ranked, $F(16,128)$=2.417, p=.003. Each group of participants with a different title had a completely different way of ranking the choices. Psychiatrists ranked the choices B (M= 1.9), C (M= 2.0), A (M= 2.8), D (M= 3.6), E (M= 4.7). Counselors ranked the choices: C (M= 1.8), D (M= 2.4), E (M=

3.0), B (M= 3.4), A (M= 4.4). Psychologists ranked them C (M= 2.2), B (M= 2.4), A (M= 2.6), D (M= 3.2), E (M= 4.7). Social workers ranked them C (M= 1.2), D (M= 2.6), B (M= 3.3), E (M= 3.9), A (M= 4.2). Lastly, those in the "other" group ranked them D (M= 2.1), C (M= 2.9), B (M= 3.0), E (M= 3.4), A (M= 3.6).

The rankings for Scenario 2 also had a statistical significance, $F(4,156) = 9.265$, $p=<.001$. Scenario 2 was about a client with BPD and depressive episodes and a history of self-injury and suicide attempts. She reports currently feeling suicidal due to stressors at home such as mom doing too much and her sister having a cold. The overall average order of rankings was C (M=2.1), D (M=2.7), B (M=2.8), A (M=3.2) and E (M=4.1). There was a statistical significance between C and E ($p=<.001$), D and E ($p=<.001$), B and E ($p=<.001$) and C and A ($p=.007$). Choice C, D and B were ranked very closely and Choice E was ranked last almost all of the time.

Many demographic variables resulted in a statistically significant difference in the way participants ordered the rankings. Each demographic variable, aside from title, had an effect. Modality had an impact on the rankings, $F(24,128)=1.635$, $p=.043$. Each modality had a different order of ranking, however, due to the low sample size of the psychoanalysis, behavioral, interpersonal and existential groups, only psychodynamic, CBT and "other" were examined. The psychodynamic group ranked the choices: C (M= 1.8), B (M= 2.1), A (M= 3.1), D (M= 3.3), E (M= 4.6). The CBT group ranked the choices: C (M= 1.7), B (M= 2.9), D (M= 3.1), A (M= 3.3), E (M= 4.0). The "other" group ranked the choices: D (M= 2.3), C (M= 2.5), A and B (M= 3.1), E (M= 4.0). The type of organization that participants worked for impacted the order of rankings as well, $F(8,160)= 2.564$, $p=.012$. Those in private practice ranked the choices C (M= 1.8), B

(M= 2.7), A (M= 3.0), D (M= 3.3), E (M= 4.2). Those in non-profit agencies ranked the choices D (M= 2.1), A (M=2.5), C (M= 2.8), B (M= 3.5), E (M= 4.1). Those in the "other" group ranked them D and E (M= 1.5), C (M= 3.0), A and B (M= 4.5). Participants who work in private practice seem more likely to try to work through suicidality in session as opposed to those in other settings. The type of degree that participants had also affected how they ranked the choices for Scenario 2, $F(8,156)=2.202$, $p=.030$. Doctorate and Graduate level participants ranked the choices very similarly in Scenario 2. Doctorate level participants ranked them: C (M=1.9),B (M= 2.6),A (M= 2.9), D (M= 3.1), E (M= 4.4), and Graduates ranked them: C (M= 2.0), B and D (M= 2.8), A (M= 3.2), E (M= 4.2). Undergraduates ranked them: D (M= 1.7), C (M= 2.2), A (M= 3.3), E (M= 3.7), B (M= 4.2). Undergraduates were more likely to utilize screening units and everyone appeared to like the choice that included the safety contract. Years of experience impacted how participants responded, $F(16,128)=1.846$, $p=.032$. The rankings were extremely varied based on years of experience. Those with the least amount of experience (under 10 years) ranked them: C (M= 1.8), A (M= 2.5), B (M= 2.6), D (M= 3.5), E (M= 4.6), while those with 10-19 years ranked them C (M= 2.25), D (M= 2.3), E (M= 3.35), B (M= 3.4), A (M= 3.7). Participants with 20-29 years of experience ranked them D (M= 2.3), C (M= 2.6), A and B (M= 2.9), E (M= 4.3). Those with 30-39 years of experience ranked them B (M=1.8), D (M= 2.2), C (M= 2.7), E (M=4.0), A (M=4.4), and those with the most experience (40+ years) ranked them C (M=1.5), A (M= 1.8), B (M=2.8), D (M= 4.0), E (M=5.0). Interestingly, those with the least and most amount of experience were least likely to utilize screening or the hospital. Lastly, the sex of the participant played a role in how participants ranked the choices for

Scenario 2, $F_{(4,168)}=5.842$, $p=<.001$. Males were more likely to rate the choices C (M= 1.9), B (M= 2.1), A (M= 2.6), D (M= 3.7), E (M= 4.7), while females ranked them C (M= 2.0), D (M= 2.1), B (M= 3.4), A (M=3.4), E (M= 3.9).

The rankings for Scenario 3 were statistically significant, $F_{(4,160)}=14.551$, $p=<.001$. Scenario 3 presented a client with BPD who was recently discharged from the hospital due to suicidality. She states that she wants to kill herself so that she can be with her father when he dies of his terminal illness. She plans on going to the store and getting 2 bottles of Tylenol to take. The overall order of the ranking was E (M= 2.0), D (M=2.2), C (M= 2.9), B (M= 3.6), A (M=4.1). There was a statistical significance for all the rankings except E to D and A to B. Choice E was statistically significantly different from Choices A and B ($p=<.001$) and C ($p=.009$). Choice D was statistically significantly different from Choice C ($p=.012$) and Choices A and B ($p=<.001$). Choice C was statistically significantly different from Choices A and B ($p=<.001$). There was a very clear distinction in the preference of choices for Scenario 3.

The only demographic variable that had influence on how participants ranked the choices for Scenario 3 was sex of the participant, $F_{(4,160)}= 5.851$, $p=<.001$. Otherwise, participants were in strong agreement as to how to respond to Scenario 3. Males and females ranked the choices in the same order; however, the responses by females were much stronger than males. Females rated the choices as follows: E (M=1.7), D (M=1.9), C (M=2.9), B (M=4.0), A (M= 4.5). Males rated the choices: E (M=2.7), D (M=2.8), C (M=2.8), B (M=3.2), A (3.4).

The rankings for Scenario 4 also had statistical significance, $F_{(4,168)}=10.191$, $p=<.001$. Scenario 4 presented a client with BPD and Mild Mental Retardation who has

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been in the hospital in the past for suicidal gestures. She has poor communication skills and is upset that her family wants her to get a volunteer job. She wants to go to the hospital because she is feeling suicidal. The overall order of the rankings for the choices was C (M=2.0), D (M=2.6), B (M=2.8), A (M=3.4), E (M=4.1). There was a statistically significant difference between the rankings for Choice C and Choice D (p=.014), Choice B (p=.020) and Choice A and E (p=<.001). There was also a statistically significant difference between Choice E and Choice D and B (p=<.001). Choice A and B had a statistically significant difference (p=.010) as well as Choice C and D (p=.014).

Multiple demographic variables impacted the way the choices were ranked for Scenario 4. Participants' title impacted how they rated the choices F(16,128)= 1.783, p=.040. All the participants except the counselors chose Choice C first and Choice E last. Counselors instead chose Choice D first and Choice A last. Counselors were more prone to utilize the screening unit and were less likely to work through the suicidality in session. Psychiatrists ranked the choices C (M=1.6), B (M=2.3), A (M=3.0), D (M=3.3), E (M=4.8). Psychologists ranked them C (M=1.9), B (M=2.5), D (M=3.1), A (M=3.2), E (M=4.4). Social workers ranked them C (M=1.9), D (M=2.5), B (M=2.6), A (M=3.6), E (M=4.4). Counselors ranked them D (M=1.7), C (M=2.4), E (M=3.2), B (M=3.3), A (M=4.5). The "other" group ranked them C (M=2.1), A (M=2.4), D (M=2.9), B (M=3.0), E (M=4.6). The level of degree of the participant affected how they rated the choices, F(8,156)=3.301, p=.002. When looking at the rankings based on degree, there is a great amount of difference. Undergraduates ranked the choices D (M=2.2), E and C (M=2.5), B (M=3.7), A (M=4.2). Graduates ranked them C (M=1.9), D (M=2.0), B (M=2.9), E (M=4.0), A (M=4.1). Doctorate level participants ranked them C (M=1.7), B (M=2.5),

A (M=3.1), D (M=3.3), E (M=4.4). The only similarities in their rankings was that the Graduate and Doctoral level participants chose the choice with the safety contract first and Undergraduates and Graduates chose the choice with holding normal sessions last. The type of organization that participants worked for had an effect on the ratings, $F(8,172)=2.017$, $p=.047$. All the participants chose the safety contract or the screening unit option first and second. Those in private practice rated the choices D (M=2.5), C (M=2.6), B (M=2.8), E (M=3.1), A (M=4.0), while those in non-profit agencies rated them C (M=1.8), D (M=2.6), B (M=2.9), A (M=3.4), E (M=4.3). Those in the "other" group rated them D (M=1.5), C (M=2.0), E (M=2.5), B (M=4.0), A (M=5.0). Lastly, the sex of the participant affected the ratings, $F(4,160)=2.919$, $p=.023$. Males ranked the choices C (M=2.0), B (M=2.6), A (M=2.7), D (M=3.1), E (M=4.6), while females ranked them C (M=2.0), D (M=2.5), B (M=3.0), A (M=3.7), E (M=3.9). Both chose the safety contract choice first, but females were more likely to choose the choice utilizing the screening units next, whereas the males chose to work through it in the session, with/without extra parameters. Both agreed that calling 911 was the last option.

Scenario 5 showed a statistical significance in how the choices were rated, $F(4,164)=5.569$, $p=<.001$. Scenario 5 is about a client new to the mental health field who recently dropped out of college. She is hopeless, says she doesn't want to live anymore and is considering cutting her wrists. The overall order of the rankings for this scenario was: C (M=2.2), D (M=2.5), B (M=2.9), A (M=3.5), E (M=3.6). There was a statistical significance between Choice C with Choice A and E ($p=<.001$) and with Choice B ($p=.007$). There was a statistical significance between Choice D with Choice A ($p=.003$) and Choice E ($p=.001$).

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Degree, organization and sex of the participant affected how participants rated the choices for Scenario 5. Degree affected the rankings significantly, $F(8,144)=3.065$, $p=.003$. Undergraduates ranked the choices D (M=1.1), C and E (M=2.6), B (M=4.1), A (M=4.7). Graduates ranked them C (M=2.0), D (M=2.4), E (M=3.2), B (M=3.3), A (M=4.1) and Doctorate level participants ranked them B (M=2.0), C (M=2.1), A (M=3.4), D (M=3.4), E (M=4.6). Participants with doctorate degrees were least likely to utilize the hospital or 911. The type of organization that the participants worked for appeared to affect the rankings, $F(8,180)=2.182$, $p=.031$. Those who work in private practice ranked them C (M=2.1), B (M=2.7), D (M=2.8), A (M=3.4) and E (M=4.0). Participants from the non-profit organization ranked them D (M=1.8), E (M=1.9), C (M=3.1), B (M=3.5) and A (M=4.6). Those in the "other" work environments rated the choices C, D and E first (M=2.5), then A (M=3.0) and B (M=4.5). Only those in private practice did not rank hospitalization and screening first. Lastly, there was a statistically significant difference based on the sex of the participant, $F(4,168)=2.469$, $p=.047$. Males ranked the choices C (M=2.2), B (M=2.4), A (M=2.9), D (M=3.1), E (M=4.4). Females ranked the choices D (M=2.1), C (M=2.2), B (M=3.3), E (M=3.4), A (M=4.0). Females were more likely to utilize screening or safety contracts, while males preferred safety contracts and extra parameters.

The rankings for Scenario 6 had a statistically significant difference, $F(4,160)= 10.781$, $p=<.001$. Scenario 6 is about a client with BPD who is being kicked out of her house. She has a history of unstable housing and friendships. She revokes consent for her family/friends and threatens to take an entire bottle of pills tonight if her friend isn't home. The average order of ranking was D (M=1.9), E (M=2.4), C (M=2.8), B (M=3.6)

and A (M=4.2). There was a statistical significance between almost all the choices. Choice A was statistically significant from Choices C, D and E (p=<.001) because Choice A was ranked last. Choice B, which was second to last was statistically significantly different from Choice C, D, and E (p=<.001). There was a statistically significant difference between Choice C and D as well (p=.041). Participants were more likely to pick the choice with hospitalization or screening for this scenario.

The only variable that had any statistical significance in ranking the choices was sex of the participant, $F(4,160) = 2.944, p$=.022. The only difference in the order of the rankings between males and females was that females chose Choice D (screening) before Choice E (911) whereas males did the opposite. Females' ratings were stronger than males. Females ranked them D (M=1.7), E (M=2.3), C (M=2.6), B (M=4.0), A (M=4.4). Males ranked them E (M=2.3), D (M=2.9), C (M=3.0), B (M=3.2) and A (M=3.7).

The last goal of the study was to examine how participants answered the statements. A Likert scale was used for participants to rate the answers: 1: Strongly Agree, 2: Somewhat Agree, 3: Somewhat Disagree, 4: Strongly Disagree. A one-way ANOVA was used to analyze all of the statements with each one of the demographic variables. Statement 5, which states that involuntarily committing someone to the hospital is a violation of their rights, showed no statistically significant differences with any variables. There was no significant difference in how any of the statements were answered based on the age the participant or the type of modality they use.

Statement 1 proposes that it is better to send clients with BPD exhibiting chronic suicidality to the hospital if the clinician does not have specialized training in treating this area. Males and females answered this question slightly differently, $F(1,58)$=4.026,

p=.049, M=1.80 as well as those with different years of experience, $F(5,52)$=2.104,

p=.008, M=1.8. Men were more likely to pick Somewhat Agree (M=2.1) whereas

women averaged between Strongly Agree and Somewhat Agree (M=1.7). Participants

with the most years of experience picked Somewhat Agree (M=2.3) whereas those with

less than a year of experience chose Strongly Agree (M=1.0). Those with 20-39 years of

experience averaged between Strongly Agree and Somewhat Agree (M=1.5 to 1.6).

Those with 1 to 19 years of experience answered Somewhat Agree (M=2.0 to 2.3).

Statement 2 only showed a difference based on years of experience,

$F(5,52)$=3.282, p=.012, M=1.97. This statement proposed that it is the responsibility of

clinicians to factor in the cost of repeatedly utilizing the hospital, including

ambulance/911 services. Those with the most experience averaged between Somewhat

Agree and Somewhat Disagree (M=2.5). Those with less than one year of experience

chose Strongly Agree (M=1.0) most often.

Statement 3 showed statistical significance based on sex of the participant,

$F(1,57)$=6.069, p=.017, M=2.24 and title, $F(4,54)$=3.197, p=.002, M=2.24. Statement 3

suggests that the clinician should not be held liable if a client breaks a safety contract and

commits suicide. Women most often answered Somewhat Agree (M=2.0), whereas men

varied between Somewhat Agree and Somewhat Disagree (M=2.7). Psychiatrists most

often answered Somewhat Disagree (M=3.4), while counselors (M=2.1) and

psychologists (M=2.3) chose Somewhat Agree and social workers averaged between

Strongly Agree and Somewhat Agree (M=1.7).

Statement 4 asks if people diagnosed with BPD should be treated any differently

from people with other diagnoses who are suicidal. This statement showed statistical

significance based on the type of organization that participants worked for, $F(3,56)=4.646, p=.006$, M=2.8. Most participants worked in private practice and they answered Somewhat Disagree (M=3.0) as did those who worked in non-profit agencies (M=2.7). Those who marked "other" for their organization chose Strongly Agree (M=1.3).

Statement 6 had statistical significance when males and females were compared, $F(1, 57)=10.864, p=.002$, M=2.27, when degree was compared, $F(3,55)=5.023, p=.004$, M=2.27 and when organizations were compared, $F(3,55)=4.002, p=.012$, M=2.27. This statement suggests that it is not in the best interest of the client to utilize hospitalization at each suicidal gesture. Women averaged between Somewhat Agree and Somewhat Disagree (M=2.6) and men averaged between Strongly Agree and Somewhat Agree (M=1.7). Those with Undergraduate degrees chose Somewhat Disagree (M=3.2) and those with Graduate degrees (M=2.4) and Doctorates (M=1.9) chose Somewhat Agree. Those in private practice chose Somewhat Agree (M=2.0) while those non-profit agencies averaged between Somewhat Agree and Somewhat Disagree (M=2.8). Those in the "other" category chose Somewhat Disagree (M=3.0).

Sex of the participant, $F(1, 57)=14.417, p=<.001$, M=2.49 and organization, $F(3,55)=3.466, p=.022$, M=2.5, were also significantly different for Statement 7. Statement 7 states that due to the increase in lawsuits against clinicians, it is better to hospitalize a client at risk of suicide rather than to attempt to work through it in an outpatient setting. Men most often chose Somewhat Disagree (M=3.0) whereas women answered Somewhat Agree (M=2.2) more frequently. Those in private practice answered mostly Somewhat Disagree (M=2.7) while those in non-profit agencies chose Somewhat

Agree (M=2.4) and those in the "other" category averaged between Strongly Agree and Somewhat Agree (M=1.5).

Statement 8 asks whether people who repeatedly self-injure, attempt or threaten suicide require a different type of treatment than those who do not. Most answered similarly, except for those in different organizations, $F(3,54)=4.625, p=.006$, M=1.6. The only reason there was a statistically significant difference was because the sample size for some of the organizations was too small. The one person in the state facility chose Strongly Disagree (M=4.0), whereas all the other organizations chose Somewhat Agree (private practice: M=1.5, non-profit: M=1.6, "other": M=1.8).

Sex of the participant, $F(1,56)=5.056, p=.028$, M=2.86, degree, $F(3,54)=7.072$ $p=<.001$, M=2.86, and title, $F(4,53)=2.448, p=.057$, M=2.86, had statistically significant differences for Statement 9. Statement 9 proposed that the screening units of hospitals are responsible for assessing the full risk of suicide rather than clinicians. Men most often chose Somewhat Disagree (M=3.3) as opposed to women who averaged between Somewhat Agree to Somewhat Disagree (M=2.7). Those with Doctorates chose Somewhat Disagree (M=3.3) and those with Graduate degrees averaged between Somewhat Agree and Somewhat Disagree (M=2.7); while those with Undergraduate degrees often chose Somewhat Agree (M=1.8). Psychiatrists often chose Strongly Disagree (M =3.6) whereas psychologists (M=3.1) and social workers (M=2.8) chose Somewhat Disagree. Those in the "other" category chose Somewhat Agree (M=2.2) and counselors averaged between Somewhat Agree and Somewhat Disagree (M=2.6).

Statement 10 had a statistically significant difference based on organization, $F(3,54)=3.087, p=.035$, M=2.16. Statement 10 states that if extra parameters (on call

availability, extra sessions) are not taken to accommodate someone who is frequently

suicidal, then the clinician is not looking out for the best interest of the client. Those in

private practice most often picked Somewhat Agree (M=1.9) and those in non-profit

agencies and "other" chose Somewhat Disagree (M=2.8).

CHAPTER IV

Discussion

Each hypothesis was supported. The title of the participant, the type of

organization he/she works for, the type of modality he/she uses, the number of years of

experience and the level of the degree of the participant affected the responses to

questions on the survey. Not each demographic variable had an effect on each question,

but all were significant in at least one question. The demographic variables that appeared

to affect the responses the most were sex of the participant, the type of organization the

participant worked for, the degree and title of the participant. It was not hypothesized

that sex of the participant would have a significant effect on the responses, however, it

was the demographic that had the most effect. A review of the responses and the

demographic variables that were significant are reviewed here.

There was not consistent agreement over Choice A in response to the scenarios.

Choice A suggested trying to resolve the suicidal thoughts in session without a safety

contract or extra parameters. Participants on average chose Somewhat Agree or

Somewhat Disagree. Participants consistently disagreed with Choice A for Scenario 3

and 6. Choice A proposes the least amount of action be taken in response to the

scenarios. Scenarios 3 and 6 have an increased number of risk factors compared to the

other scenarios. Given these two factors, it makes sense that participants would not agree

with Choice A more often. It is interesting to see that the sex of the participant had an

effect on how participants rated Choice A. Males were more likely to disagree with

Choice A than females for the first two scenarios. They answered similarly for the other scenarios. It was surprising to see how different the responses were for participants in the "other" category of organization. They answered Strongly Disagree for all but Scenario 5. All the participants in private practice and non-profit agencies chose Somewhat Agree for Scenario 1 and 2 and Somewhat Disagree for 3, 4, 5 and 6. Those in the "other" category did not specify on their surveys what type of organization they work for. Therefore, it is difficult to speculate what created the difference. Lastly, it was interesting to see that those with Undergraduate and Graduate degrees answered so similarly to Choice A for each Scenario. Those with Doctorates only differed on Scenarios 1, 2 and 5 in which they somewhat agreed with Choice A. This may be due to the increased training and experience that those with Doctorates have. They may be better equipped to handle cases of chronic suicidality in session than those without this type of degree. This has implications for who may be capable of treating BPD and chronic suicidality in therapy.

Again, the average rating for Choice B was often between Somewhat Agree and Somewhat Disagree. Choice B suggested trying to work through the suicidal feelings and thoughts in session while increasing parameters such as scheduling extra sessions and providing an on-call number. Scenario 3 and 6 seemed to have ratings for Choice B closer to the Disagree side than the other scenarios. Again, this is most likely due to the increased number of risk factors in these two scenarios. The demographic variables that seemed to most impact how Choice B was rated were title and degree. Psychiatrists more often chose Somewhat Agree than the other titles. Social workers and psychologists more often picked Somewhat Disagree. Modality appeared to impact the ratings of

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Choice B, but this was most likely due to the low number of responses by various modalities. Many modalities were not well represented in the sample. Of the modalities that were well represented, they often rated Choice B similarly. Undergraduates and Doctoral level participants differed most in their answers, which seems logical, given the different level of training. Doctoral level participants were more likely to Agree with Choice B when undergraduates were more likely to disagree. Graduate students fell somewhere in between. Again, this suggests, that based on their training, undergraduates are less comfortable than doctors when treating certain cases of suicidality in treatment.

The average rating of Choice C was Somewhat Agree, which means that participants liked this choice more than Choice A and B so far. Choice C includes a specific safety contract to use while working through the suicidal thoughts/feelings in session. When there was disagreement with Choice C, it was in response to Scenarios 3 and 6. The only variables that seemed to have an impact on the use of safety contracts, was degree and organization. Surprisingly, Graduate level students were more likely to consistently agree with using the safety contract. Undergraduates consistently disagreed with this method and Doctoral level participants seem to pick this option based on the individual scenario. They only agreed with the safety contract for Scenarios 4 and 5. The organization only seemed to make a difference when participants who had marked "other" answered. Those in private practice and non-profit agencies generally answered the same, which was Somewhat Agree. The "other" group disagreed to Scenarios 1, 2, 3 and sometimes 6. Due to these participants not specifying what type of organization they work for, it is difficult to speculate why the difference occurred.

Choice D had different ratings across the various scenarios. Choice D suggests

having a screening unit assess the client. However, Choice D was rated more favorably in response to Scenarios 3 and 6 compared to the previous choices. Participants were more likely to choose between Strongly Agree and Somewhat Agree for these two scenarios. This may be due to participants reacting to the increased risk of suicide and wanting to take action involving screeners, who are trained to assess the level or risk. For the other scenarios, the common response was somewhere between Somewhat Agree and Somewhat Disagree. It was interesting that modality and title affected how participants responded to Choice D. Again, some of the types of modalities could not be used because the sample was too small. Their answers were very different: Psychoanalysis group chose Strongly Disagree each time, the Behavioral and Interpersonal group chose Strongly Agree or Somewhat Agree, and the Existential group chose between Somewhat Agree and Disagree. Looking at the psychodynamic, CBT and "other" group, the CBT group was the only group to choose Somewhat Disagree at times. The psychodynamic and "other" group chose Somewhat Agree more frequently. Title did not have much impact on the ratings except in response to Scenario 3, 4, and 5 when some groups differed on agreement/disagreement.

Finally, Choice E had a statistically significant difference in how it was rated. Choice E suggested exploring the suicidal thoughts and calling 911 to have the client directly admitted to the hospital. Like Choice D, it was rated more favorably for Scenarios 3 and 6, most likely due to the increased risk factors and the participations' belief that hospitalization may be necessary. Modality was the only demographic variable that impacted the ratings. The largest difference was seen between the psychodynamic group versus the CBT and "other" group. The psychodynamic group disagreed much

more strongly with this choice than the others. Again, the psychoanalysis, existential, interpersonal and behavioral groups had too small of a sample to be examined.

Seeing how participants rated each of the choices gave some insight into what types of responses the participants believe to be appropriate for cases of suicidality. It was interesting to see how the demographic variables played a role in how participants rated the choices. The demographic variable that impacted the ratings of choices the most was degree. It had a bearing on Choice A, B and C. Modality, title, organization and sex all affected the ratings of two of the choices. Age and years of experience had no bearing on the ratings of choices. By looking at the rankings, it will be possible to see what response participants think is the best way to handle the individual scenarios. This can then be compared to what the literature and ethical codes suggest as the most appropriate response, to see if what is being practiced holds up to what research suggests.

There was a significant amount of difference in how participants ranked the choices for Scenario 1. Scenario 1 was about a client with Major Depressive Disorder who is feeling depressed and thinking about taking all her pills at home. The first choice was to use the safety contract with emergency numbers. The second choice was to work on the suicidality in session while increasing parameters such as extra sessions. The third choice was to call screening to have them assess her. The fourth choice was to work on her feelings through therapy with no extra parameters. The least favorite choice was to call 911 and have her directly admitted. Females were more likely to utilize the safety contract and increase parameters, while males were most likely to work through it in session with extra parameters. Only those in private practice did not choose to utilize the screening unit first. They were more likely to use safety contracts and work through it in

session, while those in the non-profit agencies and "other" group did not. Psychologists and psychiatrists were less likely to use screening units and 911 and preferred to work on it in session, with extra parameters or a safety contract. Counselors and social workers chose the safety contract and use of the screening units most often. This may be related to level of training, which is not surprising since, degree had an effect on how the choices were ranked. Doctorate level participants more often worked through the issue in session, with or without safety contracts, while Graduates and Undergraduates were most likely to use the safety contract or contact the screening units. This is similar to the answers by counselors and social workers. It appears that level of degree, along with organization and title, which are somewhat related, have a great impact on how participants respond to this type of suicidality.

The rankings for Scenario 2 also varied significantly. Scenario 2 was about a client with BPD and depressive episodes and a history of self-injury and suicide attempts. The safety contract choice was again the most popular choice, followed by having the screening unit assess the client. Next was to work on the suicidal feelings in session while raising extra parameters. Next, participants chose to work on the suicidality in session with no extra parameters and the least popular choice was to call 911 and have them admitted. This scenario depicts a picture of someone exhibiting chronic suicidality versus an acute episode of suicide, so it is interesting to see the difference. It was interesting to see the difference in rankings based on organization. It may be that non-profit agencies have specific protocol that participants have to follow, whereas, those in private practice are able to make decisions based on individual cases. It was concerning to see that those with the least amount of experience were less likely to utilize screening

and the hospital. Given that they have less experience, they might be the group who most needs to have assistance in making those decisions. On the contrary, undergraduates, who most likely have less experience or certainly less training, are more open to get assistance in assessing their suicidal client. Those with doctorates, graduate degrees and more experience were more likely to choose to work through it in sessions. It is also very interesting that females are more likely to utilize the screening units than males are. Both agreed on the safety contract choice and the 911 choice.

The rankings for Scenario 3 were very different than the rankings for Scenarios 1,2,4 and 5. Scenario 3 depicted a female who had been recently discharged from the hospital due to self-injury and suicidality, who expressed distress over the terminal illness of her father. She made comments about killing herself in order to be with him once he passes and expressed a plan to go buy two bottles of Tylenol. The most popular choice was to call 911 or utilize the screening units. The least popular choice was to work through it in regular sessions. Participants had a high level of agreement on this scenario. The only difference was how strong they rated the rankings. Females were more likely to Strongly Agree or Strongly Disagree with their rankings than males were. Scenario 3 presented a situation in which the client had previous suicide attempts, a specific plan, had recently been discharged from the hospital and the clinician had only seen the client one other time. Participants most likely chose the options of hospitalization and assessment by screeners due to the increased number of risk factors.

Scenario 4 is different from the other scenarios in that it adds a component: a dual diagnosis; BPD with Mild Mental Retardation. Scenario 4 presented a client with BPD and Mild Mental Retardation who has been in the hospital in the past for suicidal

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gestures. She has poor communication skills and is upset that her family wants her to get a volunteer job. She wants to go to the hospital because she is feeling suicidal. The most common choice was to use the safety contract, then have screening assess her or work through it in session but add extra parameters. Most did not feel it was necessary to call 911 and have her admitted. It is interesting to see how participants thought the addition of a diagnosis of Mild MR impacts the risk factors. Counselors were more likely to utilize the screening unit and were less likely to work through the suicidal feelings in session, whereas, those with another title most often chose the safety contract choice. Doctoral level participants were more comfortable working through it in session, whereas undergraduates frequently chose to call screening or 911. Graduates and doctoral level participants both chose the safety contract option first. Both Graduates and Undergraduates chose to work through it in regular session last. The level of training of the participant seems to have significant bearing on whether or not the participant feels he/she can work through it in therapy or not. Again, males were more comfortable working through the issues in session while females were more likely to choose the safety contract or to call screening. Both agreed that calling 911 was the last choice.

Scenario 5 had a statistical significance as well. Scenario 5 is about a client new to the mental health field who recently dropped out of college. She is hopeless, says she doesn't want to live anymore and is considering cutting her wrists. Again, using safety contracts was the most popular choice overall. Secondly was calling the screening unit, thirdly, to work through the suicidality in session with extra parameters. The last two choices, calling 911 and working through it in session with no extra parameters were rated much lower. This scenario is very vague and does not provide much history on the

client. It is not surprising therefore that the participants chose the choices that were less extreme. The scenario does not present as many risk factors as some of the other scenarios which may also explain why the participants chose the three middle choices. There seemed to be a pattern with the way participants with higher degrees ranked the choices. The higher the degree, the more likely the participant chose to work through the suicidality in session, whereas those with lower degrees were more likely to utilize screening or the hospital. Since working in a private practice often requires a higher degree, it seems logical that those who work in private practice correspond to the rankings of the various degrees. Males were more likely to try to work through it in session whereas females were slightly more likely to utilize screening units.

Lastly, the choices for Scenario 6 had a statistical significance in the rankings. Scenario 6 is about a client with BPD who is being kicked out of her house. She has a history of unstable housing and friendships. She revokes consent for her family/friends and threatens to take an entire bottle of pills tonight if her friend isn't home. Due to the increased amount of risk factors depicted in the scenario, the impulsivity of the client and possibly due to the diagnosis of BPD, participants ranked calling the screening unit or 911 as their first choices. Working through it in session was ranked significantly lower than these choices. This scenario is a very common picture of what can frequently happen while working with a person with BPD. Therefore, it interesting to see that based on the information given, how much more frequently screening and the hospital would be used in everyday practice to treat this type of client. The reason for this trend in the responses to the survey might be explained after looking at the statements in order to see what participants think is ethical and the best treatment for BPD.

Hypotheses one through five were all supported. Although not each demographic variable had an effect on every question on the survey, each demographic did affect answers in multiple ways. One trend that was observed was that participants with lower degrees were more apt to utilize the screening units and 911 services than those with higher degrees who more frequently would choose to work through the suicidality in session. Years of experience frequently had the same trend as level of degree. The type of organization that participants worked for seemed to affect the responses, but this may be due to certain degree requirements to work in environments such as private practice. One factor that was not predicted in a hypothesis was whether or not the sex of the participant would impact the responses. Males and females frequently had different responses. Males were more likely to choose to work through suicidality in session whereas women were more likely to rely on the screening units. Lastly, there was a significant difference in response to Scenarios 3 and 6. The largest difference between these scenarios from the others is the definitive plan of suicide in addition to the diagnosis of BPD. Participants were much more likely to choose to utilize screening and/or the hospital for these two scenarios, which has implications about how chronic suicidality may be getting treated. This is contrary to much of the recommendations found in research.

Limitations and Future Direction

This study has some limitations. First, the sample size was not large due to a small response rate. Certain demographic variables were excluded in the analysis due to such small numbers of participants, such as participants with Associates degrees, participants who work in state and inpatient facilities as well as those who use

psychoanalytic, behavioral, interpersonal and existential/Gestalt modalities. Another limitation was that a significant number of participants had to mark "other" in certain demographic categories because they did not fit into one of the choices provided. Therefore, it was difficult to make inferences about the responses of participants in any of the "other" groups.

Recommendations

Future research in this area may want to further examine what it is about the various demographic factors that contributes to the difference in responses. For example, it would be interesting to see why males and females have such varied answers. It would also be a benefit to examine the difference in responses between participants with different degrees and years of experience as this frequently affected the responses of participants. This study provokes many questions as to the disparity in handling suicidality and what can be done to train and ensure that all clinicians are doing best practice in the field.

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Appendix A

Informed Consent Form

By completing the following survey and mailing it back I am agreeing to the following...

I agree to participate in a study entitled "Chronic Self-Injury and Suicidality in Borderline Personality Disorder and Its Treatments" which is being conducted by Megan W. Perry, a student of the Clinical Mental Health Counseling Program at Rowan University.

The purpose of this study is to survey various professionals' views on what is considered ethical in treating the various levels of suicidality in Borderline Personality Disorder. The data collected in this study will be combined with data from previous studies and current research on Borderline Personality Disorder and will be used in the development of a Master's thesis and submitted for publication.

I understand that my responses will be anonymous and that all the data gathered will be confidential. I agree that any information obtained from this study may be used in any way thought best for publication or education provided that I am in no way identified and my name is not used.

I understand that there are no physical or psychological risks involved in this study and that I am free to withdraw my participation at any time without penalty.

I understand that my participation does not imply employment with the state of New Jersey, Rowan University, the principal investigator or any other project facilitator.

I understand that completing the survey will take approximately 12 minutes to complete.

If I have any questions or problems concerning my participation in this study, I may contact: Megan Perry at (856) 534-7266 or Dr. Eleanor Gaer of Rowan University at (856) 256-4872.

If I have any questions about my rights as a research subject, I may contact the Associate Provost for Research at: Rowan University Institutional Review Board for the Protection of Human Subjects at (856) 256-5150.

Results can be obtained by contacting Megan Perry at perrym50@students.rowan.edu or (856) 534-7266 as of May 2010.

Survey

1. What title best describes your occupation?
    a – Psychiatrist
    b – Counselor
    c – Psychologist
    d – Social Worker
    e – Other _____

2. What type of organization do you work for?
    a - Private practice
    b – Non-profit agency
    c – Inpatient Hospital
    d- State-run facility
    e - Other

3. What treatment modality do you utilize most frequently?
    a – Psychodynamic
    b – Cognitive Behavioral
    c – Psychoanalytic
    d – Behavioral
    e – Interpersonal Psychotherapy
    f – Existential/Gestalt
    g – Other _____

4. How many years have you worked with people with mental health diagnoses?

    _____

5. How many years have you worked with people with Borderline Personality Disorder?

    _____

6. What is the highest level of schooling you completed?
    a – Associates Degree
    b – Undergraduate Degree
    c – Graduate Degree
    d – Doctorate

7. What age bracket do you fall into?

        a – 20-30

        b – 31-40

        c – 41-50

        d –51-60

        e – 61+

8. What sex are you?

        a – Male

        b – Female

There are two parts of the survey. Please complete Section 1 and then proceed to Section 2.

Section 1: Scenarios:

Directions:
Please read the following 6 scenarios and consider how you would respond to them.

- Following each scenario are the same five possible responses: **Responses A-E**. At the end of each possible response is a scale specifying 4 different levels of agreement/disagreement. Please indicate how much you agree/disagree with each of the possible responses by circling the appropriate choice.

- Following each scenario and the possible responses and levels of agreement is a Ranking. There is a small line over letters A-E. Using the ranking system of 1st -5th, please rank the order in which you would choose to implement each Response.

 1 = First Choice of Response
 2 = Second Choice of Response
 3 = Third Choice of Response
 4 = Fourth Choice of Response
 5 = Fifth Choice of Response

1. You have a client who is a 34 year old female with a diagnosis of Major Depressive Disorder, Recurrent type. She has been a client of yours for a few months. She has a history of suicide attempts in the past and has been psychiatrically hospitalized before. She is currently living with her significant other in an apartment. As you are in session with her, she currently reports that she has been more depressed lately and is having thoughts of suicide. When you ask if she has a plan, she says that she's thought about taking the pills she has at home.

A) Explore her thoughts about suicide and discuss what is causing her to feel this way and attempt to resolve the suicidality through therapy because safety contracts are not effective.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

B) Explore her thoughts about suicide and discuss what is causing her to feel this way and attempt to resolve the suicidality through therapy because safety contracts are not effective. You increase the parameters to ensure safety by scheduling extra sessions and giving her a number to reach you at outside office hours.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

C) You explore her thoughts about it and fill out a safety contract with her which she agrees to. You include coping skills she can use and identify people she can go to for support. You give her a number she can reach if she feels she cannot abide by the contract.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

D) You explore her thoughts about it with her and then recommend she be seen by Screening to assess her for safety. You call screening and have them assess her.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

E) You explore her thoughts about it with her and call 911. You have the ambulance come out and recommend that she be directly admitted to the hospital.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

Ranking (1ˢᵗ - 5ᵗʰ):

____   ____   ____   ____   ____
A   B   C   D   E

2) You have a 25 year old female client with Borderline Personality Disorder. You have been seeing her for a few months. According to her history, she has had multiple depressive episodes as well. In the past, she has made multiple suicide attempts and has engaged in self-injury frequently. During your treatment with her, she has engaged in self-injury and has reported multiple times that she has felt suicidal. Today she comes into the session reporting that she "feels suicidal." She claims it is due to her mom having too many jobs to do and her dad isn't helping out at home and her sister has a cold.

A) Explore her thoughts about suicide and discuss what is causing her to feel this way and attempt to resolve the suicidality through therapy because safety contracts are not effective.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

B) Explore her thoughts about suicide and discuss what is causing her to feel this way and attempt to resolve the suicidality through therapy because safety contracts are not effective. You increase the parameters to ensure safety by scheduling extra sessions and giving her a number to reach you at outside office hours.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

C) You explore her thoughts about it and fill out a safety contract with her which she agrees to. You include coping skills she can use and identify people she can go to for support. You give her a number she can reach if she feels she cannot abide by the contract.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

D) You explore her thoughts about it with her and then recommend she be seen by Screening to assess her for safety. You call screening and have them assess her.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

E) You explore her thoughts about it with her and call 911. You have the ambulance come out and recommend that she be directly admitted to the hospital.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

Ranking (1st - 5th):

__   __   __   __   __
A   B   C   D   E

3) You have a 28 year old female client who is diagnosed with Borderline Personality Disorder who lives with a roommate. She is returning to you for her second appointment back since being discharged from the hospital (psychiatrically) recently (due to self-injury and suicidality). She expresses much distress due to the terminal illness of her father and she makes the statement "If I kill myself, I would get to stay with him once he passes". When you probe further, she says "I'm going to go the drug store and buy 2 bottles of Tylenol and take as many as I need to end my life."

A) Explore her thoughts about suicide and discuss what is causing her to feel this way and attempt to resolve the suicidality through therapy because safety contracts are not effective.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

B) Explore her thoughts about suicide and discuss what is causing her to feel this way and attempt to resolve the suicidality through therapy because safety contracts are not effective. You increase the parameters to ensure safety by scheduling extra sessions and giving her a number to reach you at outside office hours.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

C) You explore her thoughts about it and fill out a safety contract with her which she agrees to. You include coping skills she can use and identify people she can go to for support. You give her a number she can reach if she feels she cannot abide by the contract.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

D) You explore her thoughts about it with her and then recommend she be seen by Screening to assess her for safety. You call screening and have them assess her.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

E) You explore her thoughts about it with her and call 911. You have the ambulance come out and recommend that she be directly admitted to the hospital.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

Ranking (1st - 5th):

___   ___   ___   ___   ___
A   B   C   D   E

4) You have a 40 year old female client who is diagnosed with Borderline Personality Disorder and Mild Mental Retardation. She has been in the hospital a few times in the past due to claiming she was suicidal. She currently lives with family. She has been coming to you for a few months now and you have been working with her to help her improve her ability to communicate how she feels . She is unhappy with her family because they are asking her to find something to do during the day such as get a part time job or volunteer. She reports feeling suicidal and says she needs to go to the hospital.

A) Explore her thoughts about suicide and discuss what is causing her to feel this way and attempt to resolve the suicidality through therapy because safety contracts are not effective.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

B) Explore her thoughts about suicide and discuss what is causing her to feel this way and attempt to resolve the suicidality through therapy because safety contracts are not effective. You increase the parameters to ensure safety by scheduling extra sessions and giving her a number to reach you at outside office hours.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

C) You explore her thoughts about it and fill out a safety contract with her which she agrees to. You include coping skills she can use and identify people she can go to for support. You give her a number she can reach if she feels she cannot abide by the contract.

Strongly Agree Somewhat Agree   Somewhat Disagree   Strongly Disagree

D) You explore her thoughts about it with her and then recommend she be seen by Screening to assess her for safety. You call screening and have them assess her.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

E) You explore her thoughts about it with her and call 911. You have the ambulance come out and recommend that she be directly admitted to the hospital.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

Ranking (1ˢᵗ - 5ᵗʰ):

___   ___   ___   ___   ___
A   B   C   D   E

5) You have a client who is a 20 year old female who lives alone in her apartment. She has been seeing you for 2 weeks and has never been involved with mental health treatment before. She just recently dropped out of college. She reports that she has been feeling hopeless and doesn't want to live anymore. When asked about a plan, she admits that she has considered cutting her wrists.

A) Explore her thoughts about suicide and discuss what is causing her to feel this way and attempt to resolve the suicidality through therapy because safety contracts are not effective.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

B) Explore her thoughts about suicide and discuss what is causing her to feel this way and attempt to resolve the suicidality through therapy because safety contracts are not effective. You increase the parameters to ensure safety by scheduling extra sessions and giving her a number to reach you at outside office hours.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

C) You explore her thoughts about it and fill out a safety contract with her which she agrees to. You include coping skills she can use and identify people she can go to for support. You give her a number she can reach if she feels she cannot abide by the contract.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

D) You explore her thoughts about it with her and then recommend she be seen by Screening to assess her for safety. You call screening and have them assess her.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

E) You explore her thoughts about it with her and call 911. You have the ambulance come out and recommend that she be directly admitted to the hospital.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

Ranking (1ˢᵗ - 5ᵗʰ):

___   ___   ___   ___   ___

A   B   C   D   E

6) You have a client who is a 29 year old female who has been diagnosed with Borderline Personality Disorder. She has been staying with a friend as she does not have stable housing. She has been to many therapists in the last 2 years. She has been seeing you for one month. Given her history, you have an agreement in place about self-injury and suicidality. The client requests that you see her more frequently and revokes consent for family members. She reports she's being asked to leave her friend's place and find somewhere else to live. She reports feeling very upset by the friend's actions and is angry at her family for not taking her back in. She reports feeling suicidal and says that she is going to take a bottle of pills tonight if her friend isn't home.

A) Explore her thoughts about suicide and discuss what is causing her to feel this way and attempt to resolve the suicidality through therapy because safety contracts are not effective.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

B) Explore her thoughts about suicide and discuss what is causing her to feel this way and attempt to resolve the suicidality through therapy because safety contracts are not effective. You increase the parameters to ensure safety by scheduling extra sessions and giving her a number to reach you at outside office hours.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

C) You explore her thoughts about it and fill out a safety contract with her which she agrees to. You include coping skills she can use and identify people she can go to for support. You give her a number she can reach if she feels she cannot abide by the contract.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

D) You explore her thoughts about it with her and then recommend she be seen by Screening to assess her for safety. You call screening and have them assess her.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

E) You explore her thoughts about it with her and call 911. You have the ambulance come out and recommend that she be directly admitted to the hospital.

Strongly Agree   Somewhat Agree   Somewhat Disagree   Strongly Disagree

Ranking (1ˢᵗ - 5ᵗʰ):

___   ___   ___   ___   ___
A   B   C   D   E

Section 2: Statements:

Directions: Please read the statements and then indicate your level of agreement/disagreement by circling the appropriate response.

1) When a client with Borderline Personality Disorder is exhibiting chronic suicidality it is better to send him/her to the hospital if you don't have specialized training in treating this area.

Strongly Agree   **Somewhat Agree**   **Somewhat Disagree Strongly Disagree**

2) It is not the responsibility of clinicians to factor in the cost of repeatedly utilizing the hospital, including ambulance/911 services.

Strongly Agree   **Somewhat Agree**   **Somewhat Disagree Strongly Disagree**

3) If a client signs a safety contract and then breaks it and commits suicide; the clinician should not be held liable.

Strongly Agree   **Somewhat Agree**   **Somewhat Disagree Strongly Disagree**

4) When it comes to treating and responding to suicidal gestures/threats, people with Borderline Personality Disorder should not be treated any different than any other person with a mental health diagnosis.

Strongly Agree   **Somewhat Agree**   **Somewhat Disagree Strongly Disagree**

5) To involuntarily commit someone to the hospital psychiatrically is impeding on their rights and does not promote autonomy.

Strongly Agree   **Somewhat Agree**   **Somewhat Disagree Strongly Disagree**

6) For a client who exhibits chronic suicidal behavior, it is not in their best interest to use hospitalization at each suicidal gesture.

Strongly Agree   **Somewhat Agree**   **Somewhat Disagree**   **Strongly Disagree**

7) The incidence of lawsuits against clinicians when a client commits suicide has been increasing. Therefore, it is better to hospitalize clients who may be at risk of suicide rather than to attempt to work through it in an outpatient setting.

Strongly Agree   **Somewhat Agree**   **Somewhat Disagree**   **Strongly Disagree**

8) Treatment for people who repeatedly engage in self-injury, threats of suicide, and suicide attempts require a different type of treatment than people who infrequently become suicidal.

Strongly Agree   **Somewhat Agree**   **Somewhat Disagree**   **Strongly Disagree**

9) The screening units of hospitals are responsible for assessing the full risk of suicide rather than clinicians.

Strongly Agree   **Somewhat Agree**   **Somewhat Disagree**   **Strongly Disagree**

10) If extra parameters (i.e. extra sessions, on-call availability of the clinician) are not taken to accommodate someone who is frequently feeling suicidal, then the clinician is not looking out for the best interest of the client.

Strongly Agree   **Somewhat Agree**   **Somewhat Disagree**   **Strongly Disagree**