THE PERSONALITY OF CRISIS CLINICIANS: INHERENT TRAITS OR PROPER TRAINING IN WORKING WITH SUICIDAL AND CRISIS POPULATIONS

by

Stacey A. Caraballo

BRIANNA EITER, PhD, Faculty Mentor and Chair

KRISTA KREBS, PhD, Committee Member

DOUGLAS STYLES, PhD, Committee Member

Curtis R. Brant, PhD, Dean

Harold Abel School of Social and Behavioral Sciences

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Abstract

Crisis clinicians (CCs) are exposed to clients who are suicidal, traumatized, psychotic, and in extreme and dire emotional straits. The CC must navigate not only the clinical content of the experience with the client while maintaining rapport, but also negotiate the laws, ethics, and safety needs that are a big part of the work. This study focused on whether the CC has particular personality traits or a developed skill set (training) that allows them to work well under these urgent circumstances consistently. This type of work is very traumatizing; hence the question is raised regarding what allows crisis counselors to do this consistently. Evaluating which personality characteristics allow for a CC to stay in the field and consistently provide the intensive care, ethical practices, and necessary decision-making required to maintain a client's safety is the basis for this study. This descriptive non-experimental quantitative study employed a predictive approach to investigate whether there are differences in measures of personality traits using the International Personality Item Pool (IPIP), between CCs and non-CCs, and between CCs and Former CCs. This data analysis included *t*-tests, MANOVA, and ANOVA analyses. A disappointing level of participation (13% return) for this study did not allow for definitive predictions. However, an initial question at the start of this study was whether personality or training led to successful crisis careers. Due to the high reported level of training in the participants, it can be surmised from the results of this study that training was a mitigating factor in the success of those in this field. It is very clear from the results of this study that training is an important factor when working with such high-risk clients.

Dedication

This dissertation is dedicated to the love of my life, Luis. We have been through so many trials and tribulations throughout this process. In spite of it all, I love you now more than ever. For 28 years we have been everything to each other. I hope the next 28 and beyond are even better. I cannot thank you enough for the support and love you show me daily.

For my three beautiful children, Acacia, Adric, and Anissa, everything I do, I do for you. I hope that my journey inspires you all to reach your dreams and know that what you wish for is obtainable.

I also dedicate this dissertation to my dad, who started the journey with me, but was unable to complete it. I know you're with me in spirit.

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Special thanks go out to all my friends, family, associates, co-workers, and others who let me use them as sounding boards throughout this process.

I would like to especially acknowledge and send my sincere thanks to all the clinicians who participated in my study. You are an amazing group of people who are dedicated to the betterment of others. Your selflessness and willingness to take on the risks of this profession make you an amazing resource.

Table of Contents

List of Tables

CHAPTER 1. INTRODUCTION

Background of the Problem

Crisis Clinicians (CCs) are typically clinicians with a Master's degree in psychology or social work education and training. Not all clinicians are suited to do the demanding work that is entailed in the crisis field (Stroul, 1993). A CC must be able to manage a range of issues that cause crises in the persons they see. According to Stroul (1993) in her study on crisis centers, 35.8% of crises involved chronic mental illness; 28.6 % were concerning depression and suicidal ideation; 17% were situational events; 18.8% were resulting from substance abuse, and the remaining 17% were other types of crises (the total is greater than 100% due to overlap when more than one category fit the scenario between the different agencies studied). A CC must be able to manage those acute situations, and also be able to work with a wide range of populations: adults, children, elderly, consumers, and families; and locations: crisis call lines, jail, nursing homes, homeless situations, Emergency Departments, schools, group homes, and in some cases, on scene with law enforcement. The CC is responsible for making decisions about the outcome of the assessment to determine the best treatment course to relieve the crisis. Helping an individual stabilize and regain an optimal level of function to prevent further decompensation or disability while maintaining the safety of the client and the community are the primary goals (Stroul, 1993).

A CC works in a high stress environment and can have their skills affected by a variety of stressors. Not only are they dealing with people whose lives are currently beyond their own ability to manage, but due to the intense nature of the clients that are

seen, are at a higher risk for acquiring secondary traumatic stress (STS) which has also been labeled in the literature as vicarious trauma, compassion fatigue, or compassion stress (Ting, Jacobson, & Sanders, 2011). There is a large range of experiences in this high needs population that must be managed by the CC in a calm and efficient manner. This particular study focused on whether the CC has particular personality traits or if it's just a developed skill set (training) that allows them to work well under these urgent circumstances consistently. One of the most stressful situations facing the CC is client suicidal behavior (CSB). CSB is defined as a serious suicide attempt or suicide completion. Previous studies have shown that CSB is one of the most stressful experiences a mental health professional can encounter (Jacobson, Ting, Sanders & Harrington, 2004; Overholser, 1995; Spiegelman & Werth, Jr. 2005; Ting et al., 2011, and Veilleux, 2011). As this type of work can be very traumatizing for most clinicians, the question arises about what allows these crisis counselors to be able to do this on a consistent basis. Ascertaining what personality characteristics makes for a CC who can stay in the field and consistently provide the intensive care, ethical practices, and necessary decision-making required to maintain a client's safety is the basis for this study.

Statement of the Problem

There is little to no previous research that has investigated personality and the effects of working with clients in crisis on CCs. This research project focused on the personality traits measured by the International Personality Item Pool (IPIP) and whether there are particular traits in clinicians who work with this high risk population that show

up consistently, or if just having the skill set to do the work is all that's needed. Due to the high need of these types of clients and the minimal amount of training in graduate programs regarding crisis intervention as well as the emotional, professional, and legal risk associated with suicidal and psychotic clients, the question regarding which type of clinician has the skills or personality to do this type of work consistently is raised.

Purpose of the Study

The purpose of this study is to determine what factors keep crisis clinicians in the field of crisis work. Crisis clinicians are exposed to clients who are suicidal, traumatized, psychotic, and in extreme and dire emotional straits. The CC must navigate not only the clinical content of the experience with the client while maintaining rapport, but also negotiate the laws, ethics, and safety needs that are a big part of the work. In order to determine how to help CCs do this consistently time after time while remaining confident, able to maintain good rapport, and make appropriate decisions, requires that we determine whether this is an inherent personality factor, or if it is merely the product of good education and training.

There is little to no research about CCs who work consistently with crisis/suicidal clients. There are at least three reasons why this research is important: The high risk situations of these types of clients; the minimal amount of training in graduate and post-graduate programs regarding crisis intervention; and the emotional, professional, and legal risks associated with crisis/suicidal clients.

Significance of the Study

The main theory behind this research study is that there are certain personality traits and feelings of self-efficacy that are inherent in those mental health clinicians who choose to go into the field of crisis counseling. By utilizing the five traits identified in the International Personality Item Pool (IPIP) as it relates to Social Cognitive Theory, I believe the crisis clinicians have many of the same personality traits that are found in clinicians with the following levels of the IPIP: Neuroticism (low), Extraversion (high), Openness/Intellect (high), Agreeableness (high), and Conscientiousness (high) (IPIP, 2012). Conversely, those scoring with opposite levels of these personality traits should identify those CCs and other included counselors, with low tolerance for working with crisis/suicidal clients. In addition, it is believed that three traits in particular are protective factors for doing well as a CC. These traits are low Neuroticism, high Openness/Intellect, and high Conscientiousness. This study is expected to confirm this belief.

This study will advance the field of research by determining whether or not personality factors are what are so effective in working with crisis/suicidal individuals, or whether it is developing the skill set required to work with these clients.

Research Design

This descriptive non-experimental quantitative study employed a predictive approach to investigate whether there are differences in measures of personality traits using the International Personality Item Pool (IPIP), between CCs and non-CCs. Descriptive research is utilized when one seeks to obtain information about "what exists"

in respect to variables or conditions of the chosen situation (Nardi, 2013). In this study, surveys were used to determine if the personality traits as measured by the IPIP show any differences in the personality traits of a CC vs. a non-CC and between CCs and Former CCs. Also in question is whether experience with clients with crisis behavior impacts personality traits such as Neuroticism, Openness/Intellect, and Conscientiousness in particular. These three traits were studied between CCs and Former CCs to see if there is any validity to this belief. A predictive study is helpful to make informed decisions about future events (Nardi, 2013). In this case, knowing which type of clinician would be best suited to do crisis counseling will not only assist in finding those clinicians best suited for this intense type of counseling, but will also inform those clinicians who may not be aware that a career working with high risk client behavior could potentially cause them to experience a decrease in their confidence and perhaps change the focus of their counseling and end their desire to work in the counseling field.

When using questionnaires to conduct a study, it is important to remember that certain assumptions exist about how we understand the nature of reality. A survey is just one of the many ways of studying social phenomena, and as such, has certain limitations and strengths. The strengths of survey research is that it is fairly inexpensive to measure, can describe the characteristics of a large population, be administered to/from remote locations which makes large samples feasible and also allows for more precise measurement through standardized questions and similar data. The limitations include making sure the questions are general enough to be appropriate for all respondents, and it can be considered inflexible since the tool must remain unchanged throughout the data collection. The researcher must also hope that a large number of the selected sample will

reply to ensure statistical significance, despite being unsure that the respondents will tell the truth in their responses, especially since survey research seldom deals with context (CSU, 2012).

This study used two survey instruments: The International Personality Item Pool (IPIP), and a Demographic form, and were provided to those clinicians who are licensed, or registered intern licensees and applicants, to practice therapy in Oregon. These clinicians completed the survey instruments in an online format through Survey Gizmo, which has a dedicated site that has extra security to protect the collected data.

The role of a measure such as a personality test is devised to give a tangible form to an abstract construct, and thus measure phenomena that advance the science and practice of psychology. If one were to predict from a test to real life situation, it would be expected that personality tests would provide outcomes indicative of what the test is purported to measure. Motivational processes, cognitions, and affect are considered influenced by individual traits, or differences in dispositions, and are the complex organizational structures of the personality. Personality is developed through schemas, which are developed through interactions with individuals and their environments. These schemas then shape subsequent responses based on the individual's "interpretation of events, evaluation of self and others, and regulation of emotions, behaviors, and cognitions" (Teglassi, Simcox, & Kim, 2007, p. 225). It is through this impact to thoughts, feelings, and actions, that problem solving is facilitated by the experiences of previously gained knowledge, both academic and socioemotional. These experiences inform understanding of events and responses to current circumstances and thus comprise important structures of personality. "The development of schemas often occurs outside awareness because of

the capacity of human beings to detect, process, and use information about covariations of stimuli and events in their surroundings without conscious effort" (Teglassi et al., 2007, p. 225). Bandura's Social Cognitive Theory was utilized to look at the schemas of the individuals participating (Bandura, 1997).

In order to function well in the field of crisis counseling, the CC must have a high level of self-efficacy. Self-efficacy is a subtype of Social Cognitive Theory. For career decisions, people must acknowledge their capabilities, the stability of their interests, the type of identity they choose to construct for themselves, as well as the accessibility of the career choice. Perceived efficacy creates career interests through the "self-satisfaction derived from fulfilling personal challenges that lead to progressive mastery of occupational activities. Interest, in turn, fosters engagement in activities, which further enhances personal efficacy" (Bandura, 1997, p. 425). Bandura also goes on to state perceived efficacy is likely to promote high performance and longevity to the career through affective, cognitive, and motivational processes. Those with high self-efficacy tend to be the ones to take steps toward reaching their occupational/educational aspirations, whereas those who don't do not believe working hard is worth the effort. In the case of CCs vs. general mental health clinicians (Non-CCs), those with high self-efficacy are more likely to be the ones to stay in the field of crisis counseling due to the nature of the work, the risks involved, and the intensity of the work.

As this research is looking at the relationship of personality traits on the IPIP between CCs and Non-CCs, and between CCs and Former CCs, a between group comparison will be done to help explain the relationship. Having a comparison group that is similar to the population being studied but is different based on a particular lack of

experience as in the case of this study, will show outcomes to ascertain if these differences exist. To determine if the difference is a within group difference vs. a between group difference, MANOVA analyses will be conducted. MANOVA analyses compare the differences between the means of the groups rather than the differences between the variances to ascertain whether or not the means are really different. If the observed differences are bigger than can be expected by chance, there will be statistical significance (Hopkins, 2000). While statistical tests allow researchers to make statements with a strong level of confidence, they cannot really prove or disprove anything. If we achieve a significant result at the 95% probability level, we can state that our data is good enough to support a conclusion with 95% confidence. This 95% confidence level is considered an acceptable level for research purposes (Nardi, 2013).

Research Questions and Hypotheses

The broad research question looks at the personality differences between CCs and Non-CCs. "Is the CC group mean score of the measured values of Neuroticism, Extraversion, Openness/Intellect, Agreeableness, and Conscientiousness personality traits as measured by the IPIP significantly different than in the Non-CC group?" This included breaking down the personality test into each individual trait as compared to CCs and Non-CCs.

The second research question looks at the personality differences between Current and Former CCs. "In the CC group is there a statistically significant difference in the three specific personality traits of Neuroticism, Openness/Intellect, and Conscientiousness as measured by the IPIP than in the Former CC group?" This included

breaking down these three particular personality traits to individual differences of each trait to each group.

In order to answer these questions, the following hypotheses were tested:

The hypothesis for Research Question 1 is that there may be individual personality traits that are different between CCs and Non-CCs rather than the whole personality in general. It is believed that Neuroticism will be significantly lower and the other traits will be significantly higher between these two groups. The sub-questions look at each individual trait to ascertain difference.

The hypothesis for Research Question 2 is that there are three specific personality traits in particular (Neuroticism, Openness/Intellect, and Conscientiousness) that are necessary for being a successful crisis counselor. This hypothesis was conducted to determine if those who left the field of CC did so because the work was determined to be too challenging because of the high needs of these types of clients. The sub-questions look at each individual trait.

Assumptions and Limitations

Assumptions

The main assumption of this study is that this study only included those clinicians who are registered with the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT) and thus do not include unlicensed individuals or those who are registered with the Licensed Clinical Social Worker Board (LCSW), nor any clinicians that might be registered as licensed/unlicensed psychologists. While this could be limiting the study due to this exclusion, as many CCs and general mental health

clinicians may not be licensed, it does ensure a minimum level of education and experience amongst those included in the study. Therefore, this study assumes that all participants have at minimum, a Masters' level education, and have, or are obtaining, a minimum of two years of supervised post degree experience.

Another assumption held the participants of this study responsible to be honest in their responses to the survey questions as well as not allowing or forwarding the survey to others that did not qualify as members of the OBLPCT.

Limitations

As mentioned above, the biggest limitation is that some clinicians who work in crisis may have been unable to participate due to their not being affiliated with the OBLPCT. This study also limited the scope to personality traits to explain the differences between clinicians who do well working with clients in crisis when the potential exists for other reasons such as clinician resilience and other protective factors. An individual's cultural background was not covered and while gender was asked of each participant, this study did not compare the personality traits of men vs. women to determine resiliency as the focus was on what type of clinician the individual primarily worked (crisis vs. general mental health clinician).

Finally, the study assumed that mailing list obtained from the OBLPCT would be current and up to date, but when the survey was mailed out, it was determined that nearly a thousand of the email addresses (nearly one third) were not valid. This limited the survey substantially in terms of the numbers of potential participants.

Definition of Terms

Agreeableness: The individual differences as it relates to cooperation and social harmony. Individuals who are agreeable value getting along with others, are considerate, generous, friendly, helpful and willing to put aside their interests for other people. They tend to have an optimistic view of human nature and that others are basically decent, honest, and trustworthy. Individuals who are disagreeable place self-interest above getting along with others. They are unlikely to extend themselves for other people and are unconcerned with the well being of others. They tend to be skeptical of others' motives, which can make them unfriendly, suspicious, and uncooperative (Johnson, 2012).

Conscientiousness: This concerns the way an individual regulates, controls, and directs their impulses. Too much impulsivity can be considered anti-social, harm others, and lead to retribution toward the perpetrator of such acts. These behaviors often produce immediate rewards but undesirable, long-term consequences. Impulsivity, even if not done destructively, can diminish a person's effectiveness significantly, leading to inconsistent, small, and scattered accomplishments. Impulsivity can also affect the perception of intelligence; intelligent activity includes setting long-range goals, implementing and planning routes to these goals, and persisting in the attainment of the goals despite short-lived impulses that lead one off track. Those who are conscientious, tend to avoid trouble and achieve high levels of success through their persistence and goal attainment (Johnson, 2012).

Extraversion: This is the ability of people to interact with the outside world. Extraverts

are full of energy, enjoy being around people, and are generally positive. They are action oriented, assertive, and enthusiastic. Introverts lack the energy, activity level, and exuberance of extraverts. They prefer to be alone or in small groups of people (Johnson, 2012).

Neuroticism: The tendency to experience negative feelings (anxiety, depression, and anger) and be emotionally reactive. They respond more intensely to emotional situations, often interpret ordinary situations as threatening, and believe minor frustrations to be hopelessly difficult. Their negative emotional reactions tend to linger for long periods of time, often staying in bad moods for sustained periods. This emotional dysregulation can affect their ability to make decisions, cope with stress, and think clearly. Those who are not neurotic tend to be calm, free from long-term negative feelings, and emotionally stable (Johnson, 2012).

Openness to Experience/Intellect: People who are open, tend to appreciate art and beauty, are aware of their feelings, intellectually curious, and tend to be more individualistic and non-conforming. Their thinking tends to be more abstract than concrete. Closed individuals tend to have common, narrow interests, preferring familiarity to new or novel experiences. They are conservative and resistant to change (Johnson, 2012).

Crisis: An emotionally significant event in which an individual may become better or worse and signifies a serious disruption in the baseline level of functioning and the usual coping mechanisms are inadequate to restore the individual to a state of equilibrium. It may lead to a point where serious physical harm or life-threatening danger is imminent (Kleespies, Deleppo, Gallagher, & Niles, 1999).

Behavioral emergency: The point when an individual has reached a state of mind in which he or she is at imminent risk for causing serious harm or death to self or others unless immediate intervention occurs. There are typically four behavioral states: 1) high risk for suicide; 2) potential violence towards others; 3) a state of impaired judgment which endangers the individual; and 4) situations of risk to a defenseless victim (e.g., an abused child) (Kleespies et al., 1999).

Expected Findings

As there is little to no research on CCs and their personality, it was difficult to ascertain if these hypotheses would be accepted on the front end of the research. What may lead to rejecting the null hypothesis that CCs have different personality traits than Non-CC mental health clinicians is whether they received client suicidal behavior (CSB) and crisis specific training, which might mitigate the risk for detrimental reactions to CSB and other crises. Many mental health clinicians experience client suicidal behavior during their career, but few are as exposed to it so routinely as CCs. Suicide is considered a major stressor in the clinician. Clinicians who become distressed can become potentially harmful to themselves, coworkers, and their clients. Those exposed to CSB and other crises can experience grief, depression, personal inadequacy, guilt, shock, betrayal, and anger (Wurst et al., 2011). Wurst et al., (2011) in their study discovered those clinicians who experienced the most distress tended to have experienced more suicide. This level of distress can be interpreted two ways; these clinicians are exposed more frequently to suicidal behavior, or their level of distress did not instill the necessary trust in the clients to help them avoid suicide.

It is expected that since CCs are trained in CSB and other crisis events, and follow a set of practice standards, their feeling of mastery over these situations can possibly be a mitigating factor in helping them navigate these stressful situations and will develop the appropriate self-efficacy skills needed to be successful in this career field (Karver, Tarquini, & Caporino, 2010). Karver et al., (2010) go on to note that CCs have certain skills in determining CSB than general clinicians. Having such training across the board to all clinicians would be beneficial in lowering incidences of suicide from those seeking guidance, and thus would be beneficial in raising the self-efficacy of ALL clinicians, and not just those who may fit better in the field due to their personality (Jacobson et al., 2004; and Ting et al., 2011). It is possible that other mitigating factors such as personal trauma history, spiritual and religious beliefs, theoretical orientation, self-care activities, including the level of social support may be protective or risk factors depending on the individual. It is expected that this study will determine if it is factors such as these, or personality traits that allow CCs to consistently work with such a high-risk population (Voss Horrell, Holohan, Didion, & Vance, 2011).

Organization of the Remainder of the Study

Chapter 2 reviews the literature on the effects of suicide on clinicians, the effect of the lack of training in crisis management, risk factors in this career, secondary traumatic stress, and the theoretical orientation for the study. Chapter 3 provides relevant information related to the research methodology, study design, sampling design, instrumentation, data collection procedures, data analysis procedures, research questions and hypotheses, and expected findings. Chapter 4 shows the data collection and analysis

of the findings. Finally, chapter 5 presents conclusions and recommendations as well as the summary of the findings of the study.

CHAPTER 2. LITERATURE REVIEW

Introduction to the Literature Review

In this chapter, a review of the current and relevant literature to the study is presented. There are five areas reviewed in this literature review: The first section will review the effects of suicide on clinicians. A second section will review the literature showing that the majority of clinicians graduating from graduate programs have had little to no formal suicide/crisis/trauma assessment training. The third section will focus on the risk factors associated with working with this high-risk population (legal, emotional, ethical, and professional). Each of the aforementioned risk factors and the impact on the profession of counseling as a whole will be discussed, because there are few studies in the literature that focus specifically on the field of crisis clinicians. Secondary Traumatic Stress (STS), including protective factors will be explored in the fourth section. Finally, the fifth section will look at the research around personality traits. Determining if CCs will benefit from this focus will be ascertained by comparing the personality traits measured by the International Personality Item Pool (IPIP) between CCs and Non-CCs, and between CCs and Former CCs (Gulfi, Dransart, Heeb, & Gutjahr 2010; Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988; Ting et al., 2011; and Veilleux, 2011).

Review of Research Literature and Methodological Literature Specific to the Topic or Research Question

According to multiple studies, between 11% and 82% of clinicians, depending on whether the clinician's role is a student (11-17%), therapist/psychologist (22-39%), or psychiatrist (51-82%), will be exposed to a client who attempts or completes suicide

(Bongar & Harmatz, 1989; Gulfi et al., 2010; Packman, O'Connor Penuto, Bongar, & Orthwein, 2004; Spiegelman & Wert, Jr. 2005; and Ting et al., 2011). This can lead to substantial risk emotionally, professionally, and legally, for the clinician by leading to "feelings of professional failure and incompetence, lead professionals to question their expertise, status and role, raise concerns about possible legal repercussions, or even cause them to change their working practices" which could include leaving the field entirely (Gulfi et al., 2010, p. 202; and Jacobson, et al., 2004).

Effects of suicide on clinicians

According to Jobes (1995), suicide attempts and suicide completion are a frequently encountered clinical crisis. The assessment, management, and treatment of suicidal clients are one of the most stressful tasks for clinicians. Fowler (2012) discusses how "powerful emotional reactions to a suicidal patient can fuel a pattern of defensive behavioral management that runs the risk of eclipsing the patients suffering, leading to subtle and overt power struggles. In some cases, a pattern of chronic crisis management can emerge in which the clinician adopts a role of a constant savior" (p.81).

Multiple studies have examined the reactions of clinicians to a client suicide (Jacobson et al., 2004; Wurst et al., 2011; Dexter-Mazza, 2004; Oordt et al., 2005; Kleespies et al., 1999; and Campbell, Campbell, O'Friel & Kennedy, 2009). The consistent theme in these studies shows that clinicians "doubted their ability to provide therapeutic services, feared professional and personal criticism, increased their attention to legal matters such as charting and record keeping, and sought more frequent peer consultation after experiencing both fatal and nonfatal client suicidal behavior" (Jacobson

et al., 2004, p. 239). Not only is the suicide act itself a stressor, but the client's suicidal ideation and attempts have also been noted to be extremely traumatic, which contributes to high levels of stress and anxiety to the clinician (Jacobson et al., 2004). While the current research study did not focus on gender differences, Grad, Zavasnik, & Groleger, (1997), found that not only did female therapists experience more shame and guilt following client suicidal behavior, but they also tended to question their professional knowledge more so than their male counterparts. Female therapists were also noted to seek more professional consultation and talked more with their colleagues about their experiences to help them cope with their feelings.

Lack of training

Multiple studies have been conducted that show the majority of clinicians graduating from graduate programs have had little to no formal suicide/crisis/trauma assessment training (Bongar & Harmatz, 1989; Dexter-Mazza, 2004; Kleespies, 1993; Kleespies, Penk, & Forsyth, 1993; Knox, Burkard, Jackson, Schaak, & Hess, 2006, and Voss Horrell et al., 2011).

In a study by Cramer, Johnson, McLaughlin, Raush and Conroy (2013), it was determined that one in four trainees (internship experience) are likely to cope with suicide attempters during their clinical training, while one out of nine will experience a client who completes suicide. Cramer et al.'s (2013) research found that trainees who did experience a completed suicide tended to be significantly more distressed than those who were only dealing with suicidal ideation. Due to this risk, and the high likelihood of working with suicidal clients, training in suicide risk assessment is vital to a well-rounded

education. However, the data shows that only 40%-50% of graduate programs in clinical and counseling psychology includes formal training in suicide risk assessment and management (Bongar & Harmatz, 1989).

According to Cramer et al., (2013) there are 24 core competencies for managing individuals at risk for suicide. These competencies are divided into two competency domains to ensure a good clinical understanding of managing suicidality. The first cluster of competencies focus on the clinician's approach and attitude toward suicidal individuals: The clinician needs to "manage one's own reactions to suicide, reconcile the difference (and potential conflict) between the clinician's goal to prevent suicide and the client's goal to eliminate psychological pain via suicidal behavior, maintain a collaborative, non-adversarial stance, and finally make a realistic assessment of one's ability and time to assess and care for a suicidal client." The second cluster focuses on understanding suicidality in general. The clinician should be able to "define basic terms related to suicidality (ideation, lethality, etc.), describe the phenomenology of suicide, and demonstrate understanding of risk and protective factors" (p. 3). If clinicians received this training while they were in graduate school, they would feel more confident in their handling of suicidal clients both while in training and post graduation.

Of concern are graduate programs that minimally address suicide management by only discussing suicide assessment. This has been shown to give students a false sense of competence in their ability to effectively manage a suicidal client in ongoing treatment as they often feel this subject has been covered and they thus have the ability to understand the full realm of client suicidality (Dexter-Mazza, 2004).

Munroe (1999) suggests that educators and internship supervisors have a "Duty to Train", meaning not only should they "be concerned about warning candidates of the potential harm of being exposed to [clients in crisis and] trauma, but that [they] should also train them how to cope with this exposure" (p. 215).

Multiple studies have looked at the risk of suicide on clinicians. Jacobson et al. (2004) strongly suggest that all clinicians receive training and education focused on client suicidal behavior and should include three primary goals: "to prepare the practitioner to work effectively with suicidal clients; to understand the personal and professional impact of a client suicidal behavior as it relates to one's own practice and clinical effectiveness; and to develop and implement appropriate postvention services that help minimize the potential negative stress reaction caused by working with suicidal clients" (p. 245).

As most clinicians do not obtain adequate suicidal intervention training in their graduate programs, and often are not exposed to traumatized, highly psychotic, or dangerous clients to know how to counsel them, knowing what personality traits are best suited for this type of work would be extremely beneficial to not only those who hire CCs in order to have the most effective work force, but also to those thinking of entering the field of crisis work.

Risk Factors

Crisis clinicians (CCs) have consistent contact with psychotic, dangerous, traumatized, and suicidal clients and are therefore at the highest risk for the emotional, ethical, professional, and legal consequences of this field (Jacobson et al., 2004; Ting, Sanders, Jacobson, & Power, 2006; Veilleux, 2011; and Voss Horrell et al., 2011). In

addition, because of the nature of crisis work, mental health clinicians are exposed to more traumatized clients and situations than their non-crisis counterparts, thus putting them at greater risk for Secondary Traumatic Stress (STS). CCs work with clients who are traumatized by both childhood and recent experiences that they then share with the CC. Crisis counseling differs from general mental health counseling by the frequency and duration of contact (generally one or two intense sessions), with the CC typically not finding out the outcome of the trauma as it's resolved. The CC determines an immediate resolution to the crisis (hospitalization, respite, stabilization, etc.), but does not usually find out what happens with the client following this resolution. This lack of knowledge regarding the resolution to a client that one has worked with intensely can be traumatizing in itself.

It is crucial that crisis clinicians know how to manage a wide variety of psychopathology. CCs encounter patients who are hostile, agitated, resistant, intoxicated, paranoid, and psychotic. Knowing how to manage these behaviors is mandatory in order to achieve an optimal outcome for these encounters. Clinicians must be attuned to the signs and symptoms of withdrawal and seek medical intervention if warranted, as well as knowing the best way to interview the different presentations of clients (e.g., clear and structured questioning of psychotic patients vs. careful non-intrusive questioning of paranoid patients), and for patients who are non-responsive, observing their behaviors and determining appropriate outcomes based on these observations. The amount of training needed is clearly seen when these different patient presentations, degree of behavioral emergency, and needed crisis reducing outcome is considered.

While suicide was once considered a crime in Western countries and the individual was deemed responsible, that changed about 60 years ago. Mental health professionals can now be held liable for a client's self-harm if there's a perception that the clinician failed to properly assess the risk or take appropriate precautions when the risk was identified (Oordt et al., 2005). The clinician must actively assess for suicide risk and repeat this assessment as necessary. Suicidal behavior must be addressed in the treatment plan. Targeted treatment such as cognitive behavioral therapy should be incorporated. Ongoing risk must be considered and other medical providers, especially primary care physicians, should be advised and involved in suicide management efforts-within the bounds of appropriate confidentiality and consent. The CC has different parameters as they do not have ongoing contact with the client. When family or friends feel that something should have been done to circumvent a suicide, they turn to the law to determine fault. Suicide is the most common type of lawsuit brought against psychiatrists and psychologists (Smith et al., 2008). The following three criteria are ways in which a clinician may be held liable for a client's suicide: 1) *negligence*, which involves not being reasonably prudent to prevent another person's injury; 2) *deliberate indifference*, which is typically referenced in suicide in forensic settings; and 3) *malpractice*, which involves not meeting professional standards to protect a client from harm. Although suicide risk assessment is considered to be crucial in preventing suicide attempts and completion, many mental health professionals do not conduct adequate risk assessments. This is likely because of a "perceived lack of time to do them, anxiety about suicidal behavior in general, the mistaken belief that documentation of risk assessment can make one more vulnerable to lawsuits, and inadequate training in suicide risk assessment" (Smith et al.,

2008). While CCs are generally better trained in suicide risk assessment and are generally better prepared to assist a client in such crisis management (i.e., access to hospitalization for the client, respite, and other such follow up plans), they are also at higher risk due to the greater number of suicidal clients they encounter. If a CC fails to act appropriately with a suicidal client who then suicides, the fact that they are trained in such risk assessments heightens their risk for litigation. "A clinician who either fails to reasonably assess a patient's capacity for suicide or fails to implement a management plan based on the detection of elevated suicidal risk may be exposed to liability if the patient is harmed by a suicide attempt" (Packman et al., 2004, p. 701).

Secondary Traumatic Stress

Secondary Traumatic Stress (STS) is also known in the literature as Compassion Fatigue (Stamm, 1999 & Figley, 2003). Figley (2002) asserts that clinicians "who have enormous capacity for feeling and expressing empathy tend to be more at risk of compassion stress…resulting from helping, or wanting to help a traumatized or suffering person" (p. 1). In a study by Yassen (1995), STS can affect a clinician emotionally (e.g., hypersensitivity, depression, numbness), cognitively (e.g., trauma imagery, diminished concentration, decreased self-esteem), physically (e.g., impaired immune system, somatic reactions, chronic pain), behaviorally (e.g., abuse of alcohol or other substances, elevated startle response, sleep disturbances), interpersonally, (e.g., mistrust, isolation from friends/family, decreased interest in sex or intimacy), and spiritually (e.g., anger at God, pervasive hopelessness, loss of meaning or purpose).

According to Talbot, Manton, and Dunn (1992), crisis counseling differs from general mental health counseling in both frequency and duration of contact and especially in the intensity of the contact. Crisis interventions are typically one or two long, intense contacts between the CC and the client, whereas a Non-CC will meet with their clients for months at a time. As part of the CC assessment and intervention, CCs obtain a great deal of information, often including stories of trauma, in order to formulate the appropriate treatment outcome/recommendation. Talbot, Manton, and Dunn (1992) identified five features of crisis work that make CCs vulnerable to stress/burnout: 1) the urgency and immediacy of the response; 2) a lack of control over many of the aspects of the crisis situation; 3) small, uncomfortable, and unfamiliar surroundings; 4) little or no advance notice or time to prepare; and 5) limited amount of time/resources for developing the most effective intervention. CCs must also be alert for their own personal safety (e.g., working with psychotic and/or dangerous clients or in potentially unsafe environments, such as the client's home or on scene with police).

STS is often an impact of working with traumatized, suicidal, psychotic, and dangerous clients. Figley (1995) defines this as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing even experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 10). Within Figley's definition is the recognition that secondary traumatic stress (STS) is a "natural by-product of caring for traumatized people" (p. 15) and not the fault of the client or the weakness of the clinician. Due to the unique nature of their work, CCs may be at greater risk for developing STS/burnout than Non-CCs as a result of working with more clients who are dealing with trauma or are suicidal or psychotic

(Talbot, Manton, and Dunn, 1992). STS in CCs can manifest in a multitude of ways: In Kleespies's (1993) study, he reports that CCs often feel exhausted, have sleep disturbances and nightmares, become emotionally demanding of friends and family, develop subjective somatic symptoms such as gastrointestinal complaints and headaches, increase their alcohol intake or engage in other substance use, and experience increased sensitivity to violence.

CCs often conduct assessments in the Emergency Department (ED) of their local hospital. Ghahramanlou and Brodbeck (2000) assert that working in an ED may make a CC more vulnerable to the effects of STS due to the nature of being in the ED where the CC is exposed to more visceral stimuli that Non-CCs do not tend to witness. The CC is often exposed to acute stress reactions from friends/family of the crisis client and often may not know of the client's eventual outcome, as there may only be a one-time intervention with the client.

Multiple protective factors can help prevent burnout amongst CCs and other clinicians who work with traumatized/crisis clients. Yassen (1995) developed a comprehensive self-care plan in which she addresses personal, professional, and environmental strategies to ameliorate the deleterious effects of STS. She advocates that unless clinicians prepare for and address the effects of STS, symptomology can develop which may inevitably harm themselves, their loved ones, and/or the clients with whom they work. Her comprehensive plan includes physical (maintaining good health through exercise, healthy eating, self-care strategies such as massage, adequate sleep, surrounding the self in a pleasing/calming environment), psychological (balancing work, outside interests, social contacts, personal time, and recreation; contact with nature, creative

expression, skill development), spiritual (meditation, spiritual practice), social/interpersonal (social activism, getting help/supervision, social supports), and personal (self-awareness, humor) practices. Professional strategies include setting boundaries and limits, obtaining professional support, developing coping plans, professional training, job commitment, and balance. Her environmental strategies include developing calming environments in the social, societal, and work setting to mitigate the effects of STS. Compassion Satisfaction is an additional protective factor that clinicians experience in their role as helper. Stamm (2002) who coined the term "Compassion Satisfaction" states it represents the pleasure and positive effect clinicians may feel when they connect to and help others.

The ability to engage with others in crisis while balancing the challenges and personal experiences out of work is the very essence of crisis counseling (Cummins, Massey, & Jones, 2007). Therefore it becomes imperative that the clinician has good support and adequate supervision due to the nature of the work. To be effective, the clinician must make a connection and actively engage with clients with empathic attachment, assist the client in determining the most fitting interventions, and then separate. The ability to care is such an essential quality of the therapeutic relationship, that if the counselor is unable to care, this becomes the most dangerous indicator of burnout, ineffectiveness, and incompetence in their role, which could lead to disastrous consequences when dealing with such a high risk and potentially lethal population (Cummins et al., 2007).

Personality Traits

In doing personality research there have been multiple personality tests developed to explain the differences in humans. Personality has been defined as "(a) an individual's unique variation on the general evolutionary design for human nature, expressed as a developing pattern of (b) dispositional traits, (c) characteristic adaptations, and (d) self-defining life narrative, complexly and differentially situated (e) in culture and social context" (McAdams and Pals, 2006, p. 204). The five-factor model has been found to be a strong indicator of personality as it is robust across cultures, gender, age groups, and languages (Guenole & Chernyshenko, 2005). The Big Five was designed to provide an integrative framework for understanding the whole person by organizing broad individual differences in emotional and social life into five factor-analytically-derived categories (Extraversion, Neuroticism, Conscientiousness, Agreeableness, and Openness to experience) (McAdams and Pals, 2006). Judge, Heller, and Mount (2002) conducted a study on the five factor traits as it relates to job satisfaction. What they discovered about each of the five traits is the following: *Neuroticism*: Neurotic individuals tend to be more negative. If these events occur on the job, it could lead to lower job satisfaction. *Extraversion*: Extraverts tend to experience more positive emotions in relation to life events and as such have higher job satisfaction. These individuals have more friends and spend more time in social situations than their introverted counterparts and are likely to find work relationships more rewarding. *Openness to Experience (Intellect)*: This trait is related to artistic and scientific creativity. This particular trait does not seem to have any directional influence on job satisfaction as researched. *Agreeableness*: Because individuals with high levels of agreeableness have greater motivation to achieve

interpersonal intimacy (getting along with others in pleasant and satisfying relationships) it is believed it leads to higher levels of well-being and thus have higher life satisfaction. *Conscientiousness*: This trait represents a general work-involvement tendency and thus intrinsic (respect, recognition, feelings of personal accomplishment) and extrinsic (pay, promotions) rewards lead to job satisfaction. Guenole and Chernyshenko (2005) provide evidence through multiple meta-analyses of personality tests that personality is related to job performance. In fact, Conscientiousness and Neuroticism were found to be the most powerful predictors of occupational groups and performance criteria. These two traits refer to a willingness to exert effort and follow rules (conscientiousness) and the ability to allocate resources to accomplish tasks (neuroticism). For CCs, being extraverted is a good trait to have when needing to interact with others, particularly when that interaction is focused on influencing others, such as for determining outcomes including hospitalization (Barrick & Mount, 2005). In such a profession, being sociable, assertive, energetic, gregarious, and ambitious, increases the likelihood that a positive outcome will occur. Agreeableness is also an important factor in a CC as it is the factor associated with the helping, cooperating, and nurturing of others. A CC would not be effective in diffusing a situation if they were inflexible, argumentative, uncaring, intolerant, and disagreeable (Barrick & Mount, 2005). Openness to Experience/Intellect is related to creativity and influences the ability to adapt to change. The CC must be creative at times as they help an individual in crisis see new ways of handling their emergent situations (Barrick & Mount, 2005).

The International Personality Item Pool (IPIP) is a five-factor personality inventory that has been designed specifically to be an open domain instrument. Dr. John

A. Johnson developed the specific version of the IPIP used in an online format. He granted permission and provided this researcher with the computer program to investigate the previously mentioned research questions. This particular measure is comprised of short sentences describing various behaviors associated with each of the Big Five dimensions. The instrument has a 5-point Likert response scale (1 = very inaccurate, 2 = inaccurate, 3 = neither accurate nor inaccurate, 4 = accurate, and 5 = very accurate).

Theoretical Orientation for the Study

Mental health clinicians are frequently confronted with clients with suicidal behavior (CSB) and those that do experience it, tend to feel ill prepared to deal with the event or behaviors and be greatly affected by it (Ellis & Patel, 2012; Kleespies, 1993; and Wurst et al., 2011). The theoretical basis for this study is that those who work the most closely with high need clients who exhibit suicidal behavior or other crisis events, have certain personality characteristics that allow them to manage the stress and stay in the field of crisis work. Albert Bandura's personality theory on Self-efficacy (Social Cognitive Theory) is one way to look at what makes CCs successful at their job. According to Bandura's theory, there are four major sources of self-efficacy: 1) *Mastery experiences:* Developing a strong sense of efficacy, which can be developed through mastery experiences such as performing a task successfully. Failing at the task can weaken self-efficacy. CCs are expected to make decisions with the clients they see, up to, and including taking away their civil rights. Strong personality traits in Openness/Intellect such as creativity and insight, a broad range of interests, and the ability to bring previous experiences to their decision-making are especially pertinent traits for developing mastery (John, Naumann, & Sotto, 2008). The experience, training,

and supervision needed to work with this population have been correlated to clinician outcomes to a degree (Voss Horrell et al., 2011). 2) *Social Modeling*: The CC must be confident in their decision-making in order to consistently help their clients. Social modeling is developed after seeing others complete a task. For CCs there is an extensive training period as they learn how to be a CC and the many ways to assist the clients they see. Strong personality traits in Conscientiousness, such as thinking before acting, following norms and rules, and planning, organizing, and prioritizing tasks all help increase an individual's feelings of confidence through this social modeling (John et al., 2008). It is believed that if the clinician does not have the right personality traits and has not been trained effectively, there is a lower indicator of success in working with these clients. 3) *Social Persuasion*: Bandura states social persuasion is when people are persuaded to believe they have the skills and capabilities to succeed. Receiving verbal encouragement helps the individual overcome their self-doubt, which allows them to focus on giving their best effort on tasks. This effort is vital for those working in this field, as they must be confident enough to determine a client's level of risk and hospitalize individuals when necessary. The CC must be able to develop rapport with the client quickly. Those exhibiting strong traits of Agreeableness have attributes such as trust, kindness, affection, and other pro-social behaviors to connect with and benefit the client (John et al., 2008); and 4) *Psychological Responses*: Psychological responses are the physical reactions, emotional states, moods, and stress levels that impact the ability of the person in a given situation. These situations can be mitigated by learning how to minimize stress, elevate mood, and interpret their reactions to events (Bandura, 1994). It is important that a CC have low levels of Neuroticism, as those who have high levels tend

to exhibit emotional instability, high anxiety, irritability, and moodiness. A high level of Extraversion trait is also optimal as these traits increase the likelihood the CC will be more willing to engage with all the individuals they meet, be more talkative (and thus be able to engage with any client), assertive, and engage in high levels of emotional expressiveness (John et al., 2008). Bandura has noted that individuals with strong self-efficacy tend to recover quickly from setbacks and disappointments, develop deeper interest in activities in which they participate, view challenges as tasks to be mastered, and form a strong commitment in their activities and interests. Those who have a weak sense of self-efficacy tend to focus on negative outcomes and personal failings, believe that difficult situations and tasks are beyond their abilities, avoid challenging tasks, and quickly lose confidence in their own abilities (Bandura, 1994). I believe that those clinicians with low self-efficacy tend not to feel comfortable working with clients in crisis, or stay in the field of crisis counseling.

While it can be argued that educating ALL mental health clinicians to manage crisis and suicidal behavior is the best practice, it has not been done despite multiple studies showing the benefit, and a mandate at the federal level to include it in graduate studies and for licensure (Schmitz, Jr. et al., 2012). Understanding what personality characteristics allow certain therapists to manage on a daily, to near daily basis, psychotic or suicidal clients confidently is the major focus of this study. Additionally, this study will look at the stressors of the ethical and legal implications of working with such a high-risk population and whether having strong scores in the personality characteristics of Extraversion, Openness/Intellect, and Conscientiousness in particular, are protective factors for this career choice.

Synthesis of the Research Findings

The previous research done in the domain of crisis counseling is limited. Much research has focused on the effects of suicide on clinicians, the legal risks associated with suicide, and even personality. It does not appear that any previous research has looked at the personality types of clinicians who work with the crisis population in particular. In a study by Urbani et al., (2002), they discuss previous research that indicates a counselor's personality traits may have an impact on client outcomes. Their study suggests that counseling self-efficacy is one of three stable and reliable characteristics that could be used for selecting and training counselors. Two other characteristics were ego development and the conceptual level of the counselor. Those clinicians with high counseling self-efficacy tend to experience more positive expectancies and self-evaluations and exhibit fewer anxieties. The ability to decrease anxiety through increasing self-efficacy about one's ability to counsel leads to improved clinical judgment and performance. They suggest that the self-concept that arises out of self-efficacy impacts how accurately counselors-in-training evaluate their counseling performances. As mentioned previously, some clinicians who received minimal training in suicide assessment incorrectly accorded themselves more competent to manage client suicidal behavior, which put them at increased risk for legal consequences if their clients committed suicide. Kruger and Dunning (1999) looked at why clinicians overestimated their abilities and believe some people lack the metacognitive framework that is needed to accurately judge their own competence and because of the lack of training, may assume they know what they need to know to handle the situation. They may also tend to give themselves credit for merely having good intentions.

The research has shown that suicide is a complex behavior with significant outcomes to the individual, society, and clinicians. While it is impossible to accurately predict suicide, 34% of individuals identified as "lifetime suicide ideators" will make a suicide plan, 72% of individuals with a suicide plan will make a suicide attempt, and 26% of people with ideation and no plan will make an unplanned attempt (Nelson, Johnston, & Shrivastava (2010). These percentages suggest that there are enough indicators to prevent this behavior in at least some of this population. A clinician must be properly trained in CSB and prevention strategies and must have the personality attributes that allow them to confront this subject with their clients. Therapists typically report suicidal behaviors in clients as the most stressful part of their clinical practice. Thus, CSB is often an "occupational hazard" for psychotherapists (Jacobson et al., 2004). Fear of suicidal clients needs to be addressed so therapists who are not confident in their abilities do not avoid clients who are suicidal or psychotic, as they are the ones most in need of help. This fear may be a reason so many suicidal and psychotic clients end up in crisis services.

Critique of the Previous Research

While the previous research has done an adequate job of discussing the risks presented by minimal training in crisis behavior, it does not really discuss the intricate nature of crisis services and what a crisis counselor needs to know to be effective in their job. Crisis work has challenging tasks, schedules, and situations that are intrinsic to the job. Staff must be available 24 hours a day, seven days a week, 365 days a year, and therefore must be willing to work nights, weekends, and holidays. Their job involves outreach into unpredictable, unknown, and unstable environments and the CC must be

willing to intervene in potentially dangerous situations. The clients are often violent, hostile, dirty, and demanding. The CC must have a thorough understanding of all available resources as well as knowing how to handle any situation that presents itself. CCs are often intricately involved in working in hospital emergency rooms, which presents its own stressors. CCs are often tasked with handling emergency involuntary commitments. This can range from determining if a client's civil rights need to be taken for their own safety to processing the paperwork for the court process. CCs must often deal with "dumping" by other providers who do not feel capable of providing this type of service for their own clients due to poor training or inability to manage the conflict (Stroul, 1993). It is clear from this list that crisis services are a service that is vital to maintaining safety to citizens. However, more thorough training of all clinicians would mitigate much of this. If more research focused on the importance of managing CSB and other crisis behavior and insisted on more training amongst clinicians the field of mental health things might not get to the level of crisis before it was handled in the office.

Summary

As can be seen from the literature, client suicidal behavior and managing psychopathy can be difficult for all clinicians. The risk to the clinician as a result of little to no training, the legal risks associated with working with this population, and the personal responses following an encounter with CSB show that not all clinicians are suited to working in the field of crisis. While much of this response could be mitigated by proper training in CSB, the fact that this is not done consistently enough to show its benefit, makes it difficult to determine if training or personality is what determines the

ability to successfully manage these incidents in the counseling profession. In Stroul's (1993) extensive community survey of community crisis centers she noted that many communities regarded the personal qualities of crisis staff members were more important than a formal education. These qualities were all personality traits such as: "good judgment, flexibility, maturity, intelligence, resourcefulness, assertiveness, independence, decisiveness, and high energy" (p. 18). These communities also felt that those clinicians who were able to stay calm, cool, and collected during these stressful situations were important as well as the skills of "listening, problem-solving, decision-making, tolerating stress, handling conflict, and the ability to interact effectively with many types of families, community members, and professionals from multiple systems" (p. 18). They additionally felt the ability to handle stress and finding positive outlets to manage their personal stress to be optimal for good crisis management. If all clinicians were able to handle crises after receiving proper training, the expense of crisis services would drop considerably. Crisis services are expensive to provide and are not typically major sources of third party revenue. Most communities do not charge for crisis services, so if these services could be handled in the general clinician's office the community costs for such services would drop dramatically. Therefore, determining if any clinician is capable of working with this high-risk population is crucial for providing high quality to service to individual and community. Otherwise, knowing which clinicians are better suited to provide these services would be optimal to ensuring higher returns.

CHAPTER 3. METHODOLOGY

Purpose of the Study

The purpose of this study is to determine what factors keep crisis clinicians in the field of crisis work. Crisis clinicians are exposed to clients who are suicidal, traumatized, psychotic, and in extreme and dire emotional straits. The CC must navigate not only the clinical content of the experience with the client while maintaining rapport, but also negotiate the laws, ethics, and safety needs that are a big part of the work. In order to determine how to help CCs do this consistently time after time while remaining confident, able to maintain good rapport, and make appropriate decisions requires that we determine whether this is an inherent personality factor, or if it is merely the product of good education and training.

There is little to no research about crisis counselors who work consistently with crisis/suicidal clients. There are at least three reasons why this research is important: the high risk situations of these types of clients, the minimal amount of training in graduate and post-graduate programs regarding crisis intervention, and the emotional, professional, and legal risks associated with suicidal/crisis clients. The goal of this research is to answer the following research questions: Do the five personality traits differ between the CC group and the Non-CC group? and Do three personality traits in particular differ between Current and Former CCs?

Research Design

This descriptive, non-experimental quantitative study employed a predictive approach to investigate whether there are differences in measures of personality traits

using the International Personality Item Pool (IPIP) between CCs and Non-CCs and between CCs and Former CCs. Descriptive research is utilized when one seeks to obtain information about "what exists" in respect to variables or conditions of the chosen situation (Nardi, 2013). In this study, surveys were used to determine if the personality traits as measured by the IPIP show any differences in the personality traits of a CC vs. a Non-CC. Also in question was whether experience with clients with crisis behavior impacts personality traits such as Neuroticism, Openness/Intellect, and Conscientiousness in particular. These three traits were studied between CCs and Former CCs to see if there was any validity to this belief. A predictive study is helpful to make informed decisions about future events (Nardi, 2013). In this case, knowing which type of clinician would be best suited to do crisis counseling will not only assist in finding those clinicians best suited for this intense type of counseling, but will also inform those clinicians who may not be aware that a career working with high risk client behavior could potentially cause them to experience a decrease in their confidence and perhaps change the focus of their counseling and end their desire to work in the counseling field.

When using questionnaires to conduct a study, it is important to remember that certain assumptions exist about how we understand the nature of reality. A survey is just one of the many ways of studying social phenomena, and as such, has certain limitations and strengths. The strengths of survey research is that it is fairly inexpensive to measure, can describe the characteristics of a large population, and be administered to/from remote locations which makes large samples feasible and also allows for more precise measurement through standardized questions and similar data. The limitations include making sure the questions are general enough to be appropriate for all respondents, and it

can be considered inflexible since the tool must remain unchanged throughout the data collection. The researcher must also hope that a large number of the selected sample will reply to ensure statistical significance, despite being unsure that the respondents will tell the truth in their responses, especially since survey research seldom deals with context (CSU, 2012).

This study used two survey instruments: the International Personality Item Pool (IPIP), and a Demographic form, and was provided to those clinicians who are licensed, registered intern licensees, and applicants to practice therapy in Oregon through the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT). These clinicians completed the survey instruments in an online format through Survey Gizmo, which has a dedicated site and extra security to protect the collected data.

The role of a measure such as a personality test is devised to give a tangible form to an abstract construct, and thus measure phenomena that advance the science and practice of psychology. If one were to predict from a test to a real life situation, it would be expected that personality tests would provide outcomes indicative of what the test is purported to measure. Motivational processes, cognitions, and affect are considered influenced by individual traits, or differences in dispositions, and are the complex organizational structures of the personality. Personality is developed through schemas, which are developed through interactions with individuals and their environments. These schemas then shape subsequent responses based on the individual's "interpretation of events, evaluation of self and others, and regulation of emotions, behaviors, and cognitions" (Teglassi, Simcox, & Kim, 2007, p. 225). It is through this impact to thoughts feelings, and actions, that problem solving is facilitated by the experiences of previously

gained knowledge, both academic and socioemotional. These experiences inform understanding of events and responses to current circumstances and thus comprise important structures of personality. "The development of schemas often occurs outside awareness because of the capacity of human beings to detect, process, and use information about covariations of stimuli and events in their surroundings without conscious effort" (Teglassi et al., 2007, p. 225). Bandura's Social Cognitive Theory was utilized to look at the schemas of the participating individuals (Bandura, 1997).

In order to function well in the field of crisis counseling, the CC must have a high level of self-efficacy. Self-efficacy is a subtype of Social Cognitive Theory. For career decisions, people must acknowledge their capabilities, the stability of their interests, the type of identity they choose to construct for themselves, as well as the accessibility of their career choice. Perceived efficacy creates career interests through the "self-satisfaction derived from fulfilling personal challenges that lead to progressive mastery of occupational activities. Interest, in turn, fosters engagement in activities, which further enhances personal efficacy" (Bandura, 1997, p. 425). Bandura also goes on to state perceived efficacy is likely to promote high performance and longevity to the career through affective, cognitive, and motivational processes. Those with high self-efficacy tend to be the ones to take steps toward reaching their occupational/educational aspirations, whereas those who don't do not believe working hard is worth the effort. In the case of CCs vs. general mental health clinicians (Non-CCs), those with high self-efficacy are more likely to be the ones to stay in the field of crisis counseling due to the nature of the work, the risks involved, and the intensity of the work.

Target Population and Participant Selection

This study will focus on those mental health clinicians who specialize in crisis counseling. While most mental health clinicians are likely to be exposed to individuals who are suicidal and in crisis, it is crisis clinicians who are exposed on a near daily basis with clients who are suicidal and/or in extreme emotional distress due to a large variety of factors. A CC must be able to maintain a calm demeanor to work with these clients and be able to formulate a treatment outcome that will alleviate the crisis. The population was drawn from the mailing list of the licensed counselors and registered interns from the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT). The sample was separated between those who are currently CCs vs. those who are not CCs and between Current CCs and Former CCs.

This study used purposive sampling, as this study is about a particular subset in the mental health counseling field. A purposive sampling procedure is chosen when the researcher needs a unique sample based on particular traits or features. While this study is focused on CCs in particular, it also identifies those mental health clinicians who are not CCs or are Former CCs. It was expected that this study would provide valuable information about what personality traits may increase the likelihood that a mental health clinician becomes a CC, or at least makes them feel more successful (Nardi, 2013).

Sample size is often most dependent on how homogenous the population is that is being studied. While this study is focusing on all mental health clinicians, there was a particular focus on comparing those who are CCs to those who are not. As there may be few mental health clinicians that become CCs, a relatively large initial population was needed to get an appropriate sample size (Nardi, 2013). The study invitation was emailed

to all 3302 intern and licensed clinicians throughout the state of Oregon. Running a sample size calculation shows that for 3000 individuals (less than the 3302 listed above to account for those on the OBLPCT list who do not have email addresses listed or those that may be kicked back for no longer being a valid email) an appropriate sample size for this study is 276 participants to ensure a confidence level of 80% and confidence interval of +/- 5 (surveysystem.com, 2012). However, after the email went out, over 1200 of them were returned as bad addresses. The population then became 2015 potential participants. The confidence interval was increased to +/- 5.5 to account for the smaller population. This gave a needed sample size of 141 participants to have an 80% confidence level.

The sample for this study was taken from a pool of mental health clinicians of whom some of that population was CCs. The population consisted of all masters' level and above registered interns and licensed practitioners and therapists in the State of Oregon. The mailing list of registered and licensed clinicians is public domain and available for a nominal processing fee to anyone who seeks to obtain the list. As a specific subset of population was needed from the overall mental health clinician field, a purposive sampling procedure was used.

Participants were asked to answer basic demographic questions including whether or not they had experience with crisis/suicidal clients and if they were experiencing symptoms of burnout. To complete the IPIP they were informed they would be presented with phrases describing people's behaviors. They were asked to use a five item rating scale (1 Very inaccurate; 2 Moderately inaccurate; 3 Neither accurate nor inaccurate; 4 Moderately accurate; and 5 Very accurate) to describe how accurately each statement described each individual. They were asked to describe themselves in the following

manner: " Describer yourself as you generally are now, not as you wish to be in the future. Describe yourself as you honestly see yourself. So that you can describe yourself in an honest manner, your responses will be kept in absolute confidence. Please read each statement carefully, then click on the bubble that corresponds to the number on the scale."

Procedures

Each clinician invited to participate was emailed a description of the study, with a website link to the consent form, the demographic form, and the IPIP personality profile. The consent form included a full description of the study, an acknowledgment that the study will be completely confidential with information about how there will not be any descriptive information requested or acquired (names, IP addresses) other than what is asked on the demographic form. Contact information for the researcher was listed if any participant had any concerns or questions. Once consent was obtained, the participant was taken to the demographic form and the IPIP. The demographic questionnaire consisted of 14 questions. Participants were instructed to fill in the blanks to questions such as age, level of education, and years working in the mental health field. They were asked to identify their gender by clicking "M" or "F" and the remaining questions were asked to click "yes" or "no". Participants were not allowed to go forward in the survey unless they answered every question and were not able to go backwards in the survey. Following the demographic questions, participants were directed to the IPIP, which consisted of 120 short phrase statements such as, "Have a vivid imagination. Love to read challenging material. Trust others, etc.". They were given five choices of response to

each question ranging from Very Inaccurate to Very Accurate, as described above. Upon completion of their participation in the study, the participant was directed to a printable page of self-care ideas and links to resources if they wished to follow up on any concerns that may have arisen during the survey. They were also informed that participating in surveys including personality measures can cause the participant to become self-reflective and if any concerns arose, were encouraged to seek consultation with a respected colleague and/or obtain additional supervision or counseling. Participation in the study was voluntary and none of the respondents was remunerated financially for their participation.

Instruments

The demographic form was a 14-item self-report questionnaire developed for this study and was used to obtain basic demographic information about each participant regarding their personal variables such as age and gender, and information about their experiences working in the mental health field (see Table 1).

The 120-item IPIP scale was provided for each participant. This particular "Big Five" personality measure has been validated against the NEO Personality Inventory Revised (NEO-IP-R) by Costa & McCrae (1992), and is as well constructed as the original NEO scale (Socha, Cooper, and McCord, 2010). The "Big Five" has been deemed to be the dominant model of personality structure in psychology traits (Donnellan, Oswald, Baird, & Lucas, 2006). In reviewing several studies utilizing the IPIP scales, it has been consistently found that the co-efficient $\propto$ reliabilities generally match or exceed the reliabilities of the NEO scales with a Chronbach's alpha of .90 for the IPIP overall scale and individually with Chronbach alpha scales of .91 for

Extraversion, .88 for Agreeableness, .88 for Conscientiousness, .91 for Neuroticism, and .90 for Openness – Intellect/Imagination (Goldberg, 1992; Goldberg et al., 2006; Buchanan, Johnson, & Goldberg, 2005; Socha, et al., 2010).

There are no norms listed on the web site for the IPIP as Goldberg, developer of the IPIP, insists that norms are generally misleading as it is typically not the case that the norms have been established for the participant pool they will be used on, and therefore are not included. Published personality tests have the tendency to become static over time, as there is no incentive for the publishers to compare the scale with other measures, thus Goldberg developed the IPIP to allow researchers to compare the scales and improve the validity (IPIP.org; Thalmayer, Saucier, & Eigenhuis, 2011). One difference between the IPIP and the NEO-IP-R is the fifth factor, which Costa and McCrae define as "Openness to Experience" (1992). Goldberg has defined it as "Intellect/Imagination". The Agreeableness factor also differs in that it emphasizes empathy and an interest in others rather than focusing on quarrelsomeness (IPIP, 2012), Thalmayer et al., 2011). The emphasis on empathy and interest in others was more important to this study than quarrelsomeness.

The IPIP scale is an open domain instrument and permission is not necessary as long as it is appropriately cited. In order to obtain a program that provided the respondent analysis to the IPIP scales, Dr. John A. Johnson of Pennsylvania State University provided permission and programming information.

The web link for Dr. Johnson's IPIP program is as follows:

http://www.personal.psu.edu/~j5j/IPIP/ipipneo120.htm

Table 1: *Items on Demographic Information Form*

Variable	Item
Age	1. What is your current age?
Gender	2. What is your gender? M or F
Education	3. What is your level of education?
Graduate training in crisis work	4. Did you receive any training during your graduate program to work with clients in crisis (suicidal, psychotic, traumatized, extreme emotional dysregulation)? Y or N
Post-Graduate training in crisis work	5. Did you receive any training during your POST-graduate career to work with clients in crisis (suicidal, psychotic, traumatized, extreme emotional dysregulation)? Y or N
Years working in mental health	6. How many years have you spent working in the mental health field? _____
Experience working with clients in crisis	7. Have you done any crisis counseling (work closely with suicidal, psychotic, traumatized, or extreme emotionally dysregulated clients)? Y or N
Currently a crisis counselor	8. Is your current primary job description a crisis counselor? Y or N
Previous work as crisis counselor	9. Have you previously worked as a crisis counselor, but are not currently? Y or N
Left field of CC due to nature of work	10. If you did previously work as a crisis counselor, but no longer are, did you leave that position due to the nature of the work (working with high risk clients)? Y or N
Worked with clients in crisis	11. Have you worked at any time with crisis clients (suicidal, psychotic, traumatized, in extreme emotional dysregulation), even if only minimally? Y or N
Symptoms of burnout	12. Have you experienced any symptoms of compassion fatigue/burnout (A state of physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations)? Y or N
Support/Supervision	13. Do you receive/access good support and supervision? Y or N
Enjoy job	14. Do you enjoy your job? Y or N

Research Questions and Hypotheses

The present study examined the measured values of five personality traits (Neuroticism, Extraversion, Openness/Intellect, Agreeableness, and Conscientiousness) between CCs and Non-CCs, and CCs and Former CCs to determine if a statistically significant difference could be noted between the groups to account for why some clinicians work well with clients in crisis and others do not. The two research questions are as follows:

> Research Question 1: Is the CC group mean score of the measured values of Neuroticism, Extraversion, Openness/Intellect, Agreeableness, and Conscientiousness personality traits as measured by the IPIP significantly different in the Non-CC group?
>
> Research Question 2: In the CC group is there a statistically significant difference in the three specific personality traits of Neuroticism, Openness/Intellect, and Conscientiousness as measured by the IPIP than in the Former CC group?

Hypothesis 1

The hypothesis for Research Question 1 is that there may be individual personality traits that are different between CCs and Non-CCs rather than the whole personality in general. It is believed that Neuroticism will be significantly lower and the other traits will be significantly higher between these two groups. The sub-questions look at each individual trait to ascertain difference.

HA) The CC group mean score of the measure values of Neuroticism, Extraversion, Openness/Intellect, Agreeableness, and Conscientiousness personality traits

as measured by the IPIP is significantly different than in the Non-CC group.

HO) The CC group mean score of the measured values of Neuroticism, Extraversion, Openness/Intellect, Agreeableness, and Conscientiousness personality traits as measured by the IPIP will not be significantly different than in the Non-CC group.

Sub-Question 1: Is the CC group mean score of Neuroticism as measured by the IPIP significantly lower than in the Non-CC group?

HA) The CC group mean score of Neuroticism as measured by the IPIP will be significantly lower than in the Non-CC group.

HO) The CC group mean score of Neuroticism as measured by the IPIP will not be significantly different than the Non-CC group.

Sub-Question 2: Is the CC group mean score of Extraversion as measured by the IPIP significantly higher than in the Non-CC group?

HA) The CC group mean score of Extraversion as measured by the IPIP will be significantly higher than in the Non-CC group.

HO) The CC group score of Extraversion as measured by the IPIP will not be significantly different than the Non-CC group.

Sub-Question 3: Is the CC group mean score of Openness/Intellect as measured by the IPIP significantly higher than in the Non-CC group?

HA) The CC group mean score of the Openness/Intellect as measured by the IPIP will be significantly higher than the Non-CC group.

HO) The CC group mean score of Openness/Intellect as measured by the IPIP will not be significantly than in the Non-CC group.

Sub-Question 4: Is the CC group mean score of Agreeableness as measured by the IPIP significantly higher than the Non-CC group?

HA) The CC group mean score of Agreeableness as measured by the IPIP will be significantly higher than the Non-CC group.

HO) The CC group mean score of Agreeableness as measure by the IPIP will not be significantly different than in the Non-CC group.

Sub-Question 5: Is the CC group mean score of Conscientiousness as measured by the IPIP significantly higher than the Non-CC group?

HA) The CC group mean score of Conscientiousness as measured by the IPIP will be significantly higher than the Non-CC group.

HO) The CC group mean score of Conscientiousness as measured by the IPIP will not be significantly different than in the Non-CC group.

Hypothesis 2

The hypothesis for Research Question 2 is that there are three specific personality traits in particular (Neuroticism, Openness/Intellect, and Conscientiousness) that are necessary for being a successful crisis counselor. This hypothesis was conducted to determine if those who left the field of CC did so because the work was determined to be too challenging because of the high needs of these types of clients. The sub-questions look at each individual trait.

HA) In the CC group there will be a statistically significant difference in the three specific personality traits of Neuroticism, Openness/Intellect, and Conscientiousness as measured by the IPIP than in the Former CC group.

HO) In the CC group the three specific personality traits of Neuroticism, Openness/Intellect, and Conscientiousness as measured by the IPIP will not have a statistically significant difference than in the Former CC group.

Sub-Question 1: Is the CC group mean score of Neuroticism as measured by the IPIP significantly lower than in the Former CC group?

HA) The CC group mean score of Neuroticism as measured by the IPIP will be significantly lower than in the Former CC group.

HO) The CC group mean score of Neuroticism as measured by the IPIP will not be significantly different than in the Former CC group.

Sub-Question 2: Is the CC group mean score of Openness/Intellect as measured by the IPIP significantly higher than in the Former CC group?

HA) The CC group mean score of Openness/Intellect as measured by the IPIP will be significantly higher than in the Former CC group.

HO) The CC group mean score of Openness/Intellect as measured by the IPIP will not be significantly different than in the Former CC group.

Sub-Question 3: Is the CC group mean score of Conscientiousness as measured by the IPIP significantly higher than in the Former CC group?

HA) The CC group mean score of Conscientiousness as measured by the IPIP will be significantly higher than in the Former CC group.

Data Analysis

Experimental designs are the most rigorous standard for conducting research and can predict causal relationships, but when one is conducting research on a topic as nebulous as personality, this becomes impossible to determine with such a method. This

was a non-experimental study using a between group comparison and was done to help explain the relationship of personality traits on the IPIP between CCs and Non-CCs. A comparison group that is similar to the population that is being studied, but is different based on a particular lack of experience as in the case of this study, will show outcomes to ascertain if these differences exist. To determine if the difference is a within group vs. a between group difference, MANOVA analyses were conducted. MANOVA analyses compare the differences between the means of the groups rather than the differences between the variables to ascertain whether or not the means are really different. If the observed differences are bigger than can be expected by chance, there will be statistical significance (Hopkins, 2000). While statistical tests allow researchers to make statements with a strong level of confidence, they cannot really prove or disprove anything. The null hypotheses will be accepted or rejected based on a test of statistical significance with a specific level of confidence of $p < 0.05$, which is generally accepted in social science research to avoid type 1 errors (Gravetter & Wallnau, 2007).

A field test was done utilizing friends and family who did not meet inclusion criteria to test the electronic arrangement of the instruments and their results were not included in the data analysis. IRB approval from Capella University was obtained prior to the field test.

All participants were directed to a website developed exclusively for this study and hosted by Survey Gizmo. The site did not collect any identifying information and therefore the participants remained completely anonymous. The participants were able to log onto the website as many times as necessary to complete the survey. They also received a printable list of self-care suggestions and links to helpful websites. Once the

surveys were completed, the participants were not able to access the survey section again. The storage and protection of the data, and maintaining the confidentiality of the research were paramount to ensure each participant's protection for the study to remain ethically solvent. Care was taken to ensure confidentiality for all participants throughout the process. All data obtained was protected throughout each step of the process and will be protected for seven years after the conclusion of the study. The data will be kept in a locked cabinet in the researcher's home as required by Capella University. The electronic information will be saved on this researcher's personal computer under double password protection, and emails were sent from a newly developed email address that was only utilized for this study. Following the acceptance of the dissertation, these emails will be destroyed so as not to cause any issues with security and ensure private contact information can neither be shared nor inadvertently incur a breach of confidentiality. The data to be analyzed were the five personality factors garnered from the IPIP. This was factored in a MANOVA analysis between CCs and Non-CCs, and CCs and Former CCs.

The preparation of the raw data is an integral process for data analysis. Boslaugh and Watters (2008) state the data must be cleaned, organized, and made ready for analysis as part of the preparation process. Once the data was obtained it was exported from the website to Microsoft Excel to allow for export to the statistical SPSS program. For the data analysis, the data was screened for accuracy, missing data, outliers, and to what level it meets the basic assumptions for linearity, normality, and homoscedasticity (Mertler & Vannatta, 2005). The demographic information was evaluated using descriptive statistics.

Descriptive statistics are routinely used when there is a significant amount of quantitative data and help to summarize and support the assertions of fact. It is recommended when the objective is to describe the acquired data set rather than trying to interpret information, which would otherwise be difficult to ascertain from raw data alone (TSAO 1995). Intercorrelations were conducted on some of the demographic variables and the primary variables to determine why statistically significant relationships occur (Mertler & Vannatta, 2005). This data analysis included MANOVA, ANOVA, and *t*-test analyses to ascertain whether there were differences between the groups being analyzed. A *t*-test is a random variable that uses the standard deviation of the sample utilized when one wants to determine if the sample shows anything interesting about the larger group. In doing this analysis, the average of the values from the sample were obtained, and the average of the larger population it was drawn from to determine the standard deviation of the value from the sample and the number of values in the sample (Niles, 2012). However, as there are several tests that need to be run, it becomes more powerful to analyze all the data at once rather than running a series of *t*-tests between all the pairs of levels. This is called the multiple one-way analyses of variance (MANOVA), with the test statistic of the F ratio. By analyzing the means of two groups by MANOVA, the same results will occur as would be done with running a *t*-test. MANOVA is used as it is concerned with differences between means of groups not the differences that occur between the variances. It looks to see what the variation is within the groups, and then looks at how that will translate into the differences between the groups based on the number of subjects in the group. If the observed differences are quite a bit bigger than would be expected by chance, there will be statistical significance (Hopkins, 2000). Once

the MANOVA was calculated, further analysis through ANOVA was conducted to locate where the significant difference was found. Finally, *t* tests were conducted to determine exactly where significance occurred.

Statistical significance determines whether or not to accept or reject a null hypothesis based on at least a $p < 0.05$-confidence level (Nardi, 2013). To determine whether or not personality traits as defined on the IPIP resulted in a better than chance prediction of higher scores between CCs vs. Non-CCs, and CCs vs. Former CCs, a *logistical regression analysis* was conducted to ascertain any statistically significant relationships between the predictive variables (personality traits) and outcome variables (CC, Non-CC, Former CC) based on training in crisis work, worked/working with crisis clients, and stayed/left the field of crisis counseling), and whether any of these variables were more influential than others in predicting personality type for CCs (Nardi, 2013). A logistical regression allows the researcher to examine the influence of several variables in a specific order depending on the order they are entered into the analysis. Typically, those believed to be the most influential are entered into the analysis first (Nardi, 2013).

Ethical Considerations

When research is conducted, it is imperative that the appropriate ethical guidelines are followed to protect the participants. Researchers must anticipate and address any ethical issue presented throughout the duration of the study. Utilizing the Institutional Review Board (IRB) ensures the safeguarding of research participants. The IRB is the guardian of the rights and welfare of human research subjects and assess the potential risk of harm that could be incurred through economic, legal, social, physical, and psychological incidents (Chadwick and Dunn, 2000).

General Precautions

To ensure the protection and ethical treatment of both the research participants and their records, the researcher submitted an application to the Capella University Institutional Review Board prior to commencing the request for participation of the research participants and the data collection process. The study was conducted on Survey Gizmo and thus made it easy for them to access the survey. Survey Gizmo is password protected and has built in firewalls to ensure confidentiality is maintained. All participants were required to read and accept the informed consent before accessing the survey. Email addresses and names were in no way linked to the participant identity or their responses. All electronic and physical data collected during the course of the research was protected at all times and the data will be protected for seven years in the researcher's home and on the researcher's personal computer under password protection as required by Capella University.

Compliance with the Belmont Report

The Belmont Report (1979) was established following the National Research Act of 1974 and summarizes the ethical principles identified by the National Commission. These principles and guidelines are intended to assist researchers conducting research on humans to manage any ethical problems or concerns that arise during the study. Within this report there are three basic ethical principles that must be addressed when utilizing human subjects. These three principles are: respect of persons (addresses autonomy and the need for protection for those who have diminished autonomy), justice (ensuring equal treatment to participants in receiving a fair distribution of benefits and burdens), and

beneficence (the concept of respecting participant decisions, making efforts to secure their well-being, and protecting them from harm) (The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1974).

In addition to the Belmont Report (1979), clinicians must abide by the ethical standards of the American Counseling Association (ACA, 2005). The ACA standards for research and publication focus on five areas: agreement for identification, disclosure of research information, adherence to guideline, confidentiality of information obtained, and institutional approval. Approval must be obtained prior to conducting research, providing accurate information when seeking institution approval, and the researcher must agree to conduct the research in accordance to the approved protocol. All agency, state, federal and institutional policies for confidentiality must be followed throughout the research process.

The ACA (2005) warns clinicians that privacy and confidentiality violations place participants at risk for harm. This warning especially concerns researchers who must maintain all records in a secure manner. Neither counselors nor researchers are permitted to disclose confidential information that could reasonably lead to the identification of the participants unless the participant provided consent. Participants must be informed about the limits of confidentiality and that there are potential risks for violating this privacy and confidentiality. Due to this warning, researchers must disclose the level of risk the participants can reasonably expect when participating in a research study and any use of that data must be disguised to assure participant anonymity (ACA, 2005).

Expected Findings

It is my belief that personality traits between CCs and Non-CCs are different. I expected that those CCs who work successfully in the crisis field and are happy in their career would have lower levels of Neuroticism and higher levels of Conscientiousness, Agreeableness, Openness/Intellect, and Extraversion than Non-CCs. Further, I expected that the levels of Conscientiousness, Neuroticism, and Openness/Intellect would be significantly different between CCs and Former CCs as they would likely feel more comfortable working with suicidal/crisis behavior.

As there is little to no research on CCs and their personality, it was difficult to ascertain if these hypotheses would be accepted on the front end of the research. What may lead to rejecting the null hypothesis that CCs have different personality traits than Non-CC mental health clinicians is whether they received CSB and crisis specific training, which might mitigate the risk for detrimental reactions to CSB and other crisis. Many mental health clinicians experience client suicidal behavior during their career, but few are as exposed to it so routinely as CCs. Suicide is considered a major stressor in the clinician. Clinicians who become distressed can become potentially harmful to themselves, coworkers, and their clients. Those exposed to CSB and other crises can experience grief, depression, personal inadequacy, guilt, shock, betrayal, and anger (Wurst et al., 2011). Wurst et al., (2011) in their study discovered those clinicians who experienced the most distress tended to have experienced more suicide. This level of distress can be interpreted in two ways; these clinicians are exposed more frequently to suicidal behavior, or their level of distress did not instill the necessary trust in clients to help them avoid suicide.

It is expected that since CCs are trained in CSB and other crisis events and follow a set of practice standards, their feeling of mastery over these situations can possibly be a mitigating factor in helping them navigate these stressful situations and will develop the appropriate self-efficacy skills needed to be successful in this career field (Karver et al., 2010). Karver, et al., (2010) go on to note that CCs have certain skills in determining CSB than general clinicians. Having such training across the board to all clinicians would be beneficial in lowering the incidences of suicide from those seeking guidance, and thus would be beneficial in raising the self-efficacy of ALL clinicians, and not just those who may fit better in the field due to their personality (Jacobson et al., 2004; and Ting et al., 2011). It is possible that other mitigating factors such as personal trauma history, spiritual and religious beliefs, theoretical orientation, self-care activities, including the level of social support may be protective or risk factors depending on the individual. It was expected that this study would determine if it is factors such as these, or personality traits that allow CCs to consistently work with such a high-risk population (Voss Horrell et al., 2011).

CHAPTER 4. DATA COLLECTION AND ANALYSIS

Introduction

As presented in Chapter 1, this research study provided an in-depth examination of the personality types of three types of clinicians, Crisis Clinicians (CCs), general mental health clinicians (Non-CCs) and Former Crisis Clinicians (Former CCs) as it relates to the ability of these clinicians to work with clients who are suicidal or experiencing psychiatric crisis. This chapter presents the findings from the statistical analyses performed on the data obtained from the survey conducted on Licensed Professional Counselors and Therapists including registered interns and applicants for licensure in the State of Oregon. The first section will give an overview of the study. The next section includes the data analysis and focuses on the results obtained from the demographic questionnaire and the responses on the International Personality Item Pool (IPIP). The second part of the section will discuss each of the proposed research hypotheses. That section will report the differences in personality traits between each group of clinicians (CC vs. Non-CC, CC vs. Former CC, and Non-CC vs. Former CC).

Participants were asked to complete demographic survey questions including whether or not they had worked with clients in crisis, if they had received training in both graduate school and post-graduate school to work with these clients, and if they had ever experienced job burnout. Participants were asked to complete the International Personality Item Pool (IPIP), which is a 120-item personality test that focuses on the five personality factors of Neuroticism, Conscientiousness, Agreeableness, Openness/Intellect, and Extraversion. The demographic and IPIP data were compared between the three groups.

Prior to conducting analyses, data were imported into SPSS 16.0 from Excel. Following the IPIP recommendations, negatively worded items were rescaled, and all items were summed to create a score on each dimension. All participants had to respond to all questions in order for their responses to be included in the analysis. The continuously valued variables, including the personality factors, were examined for normal distribution and outliers. All continuous variables were normally distributed and no outliers were found; as such, data analysis proceeded.

Description of the Sample

The sample was a population of 3302 licensed professional counselors and registered interns obtained from the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT). The mailing list was obtained after paying a nominal fee. The study was initially mailed to 3302 potential participants, but 1287 were returned as bad addresses. This left a potential population of 2015. Of this population, 280 counselors responded, for a 13.9% response rate. Once the data were examined, 14 participants had not answered all the questions and their data were removed prior to analysis. This left 266 respondents (13.2%) to be included in the study. It was later determined that the source of the mailing list (OBLPCT) does not delete email addresses from retired/deceased members, nor do they conduct yearly updates of their records. Participants were chosen from members of the Oregon Board of Licensed Professional Counselors and Therapists in order to ensure equal minimal levels of education, experience, and adherence to a code of ethics.

The survey was open from April 17, 2013 to June 19, 2013 on the Survey Gizmo Web site. Reminder letters were mailed out three times over two week intervals. As this researcher is a crisis counselor, being included in the mailing list helped to ascertain if the email invitations were being distributed. I only received the first invitation and did not receive the next two mailings. It is likely it was caught in the spam filter even though the email was distributed directly by Survey Gizmo. The final mailing to all participants was sent directly from my work email. This email arrived in my inbox, and a few more people responded (34 participants) once this final email went out. It appears that spam filtering was a significant challenge to this study.

Demographic Information Form

Information about the respondents was obtained from the Demographic Information Form. All respondents held at least a master's degree with several having more than one master's degree or doctorates. Their experience in the field ranged from one year to 46 years with the largest concentrations of participants between three and 20 years of experience. Nearly all respondents worked at some point with clients in crisis (only two participants stated they had never worked with a client in crisis, even if only minimally). Of all participants, 86% report receiving good support and supervision and 95% report they enjoy their job. The age of the participants ranged from 27 to 75. The gender breakdown was 78% female and 22% male. Crisis training was an emphasis in this study with 76% receiving training in the graduate school training and 90% receiving training in their post-graduate years. Eleven percent identified as crisis counselors and 32% identified as having worked as crisis counselors in the past. Of those that previously worked as crisis counselors, only 5% left the field due to working with clients in crisis.

Another focus of the demographic form was how many experienced compassion fatigue/burnout. While 71% admit to experiencing these symptoms, 95% of the respondents report they like their jobs and 86% manage this by accessing good support and supervision.

Summary of the Results

Of the 280 returned surveys, only 266 were fully completed thus resulting in 266 valid surveys. Of that 266, 153 were Non-CCs (58%), 81 were Former CCs (30%), and 32 were Current CCs (12%). According to the power analysis, 141 participants were needed to achieve power of .80 for a MANOVA analysis comparing the three groups on the five personality traits, assuming a medium global effect size. This study therefore had adequate power to detect a medium effect.

The research questions that were investigated were:

1). Are the mean scores of the measured values of Neuroticism, Extraversion, Openness/Intellect, Agreeableness, and Conscientiousness personality traits as measured by the IPIP significantly different for the CC group and Non-CC group?

2). Are the mean scores of the three specific personality traits of Neuroticism, Openness/Intellect, and Conscientiousness as measured by the IPIP significantly different for the CC group and Former CC group?

Initial analyses were conducted to separate the data into the three identified groups (Current CC, Non-CC, and Former CC). Analyses were conducted to ascertain if key questions on the demographic form showed any significant differences between the three groups.

Table 2 *Demographic Information*

		Non-CC	Current CC	Former CC
		n = 153	n= 32	n=81
Gender	Male	31 (20.3%)	5 (15.6%)	23 (28.4%)
	Female	122 (79.7%)	27 (84.4%)	58 (71.6%)
Age	Mean	47	45	49
	Std Dev	12	12	12
Grad School Training	No	33 (21.6%)	9 (28.1%)	22 (27.2%)
	Yes	120 (78.4%)	23 (71.9%)	59 (72.8%)
Post-grad Training	No	19 (12.4%)	2 (6.3%)	6 (7.4%)
	Yes	134 (87.6%)	30 (93.8%)	75 (92.6%)
Compassion/ Burnout	No	38 (24.8%)	5 (15.6%)	34 (42.0%)
	Yes	175 (75.2%)	27 (84.4%)	47 (58.0%)

Note: Percentage of the total sample appears in parentheses.

Table 2 shows the breakdown of demographic characteristics for the three groups. Seventy-eight percent of the total respondents were female and 22% were male. It was expected that a higher proportion of respondents would be female as there are more females than males in the counseling profession. The majority of the participants were roughly the same age with a mean of all groups of 47 (sd =12). A high proportion of the participants reported receiving training in their graduate programs to work with suicidal clients (76%), and 94% reported that they received training for this population in their post-graduate career. It is interesting to note the very high percentage of participants who received training, as that is higher than the level that was noted in previous research, which showed that only 40-50% of graduates received any training in working with suicidal and crisis training in their graduate programs (Bongar & Harmatz, 1989; Dexter-Mazza, 2004; Kleespies et al., 1993; Knox et al., 1995; and Voss et al., 2011).

Chi-square tests were conducted to ascertain if the CC groups were statistically significantly different on the proportion of participants that received training. These tests showed that the proportion of participants that received training was not significantly different across the three groups ($\chi^2(2) = 1.24$, $p = .54$).

Working with people in crisis can often lead to compassion fatigue or symptoms of burnout (emotional exhaustion, alienation from job-related activities, and reduced performance at work) (Yassen, 1995). A chi-square test was conducted on the three groups regarding their experience with burnout as many clinicians can experience compassion fatigue/burnout due to the nature of the work. A substantial portion of the respondents stated they have experienced symptoms of compassion fatigue/burnout (Former CC 58%, Non-CC 75%, and Current CC 84%). The chi-square analysis showed that there was a significant difference in the proportion of participants reporting compassion fatigue/burnout across the three groups ($\chi^2(2) = 10.70$, $p = .01$). Follow-up chi-square analyses were conducted to determine which of the three groups were significantly different from one another. These follow-up analyses revealed that the Current CC group had a significantly higher proportion of participants experiencing symptoms of compassion fatigue/burnout than the Former CC group ($\chi^2(1) = 7.05$, $p = .01$). However, when compared together, the Current CC and Non-CC group were not significantly different ($\chi^2(1) = 1.26$, $p = .26$). Therefore, both the Current and Non-CC group reported experiencing compassion fatigue/burnout to a similar degree, as 15 of the total participants noted they left the field of crisis counseling due to conditions of working with this population.

International Personality Item Pool (IPIP)

The International Personality Item Pool (IPIP) is a five-factor personality inventory that has been designed specifically to be an open domain instrument. Dr. John A. Johnson developed the specific version of the IPIP used in an online format. He granted permission and provided this researcher with the computer program to investigate the previously mentioned research questions. This particular measure is comprised of 120 short phrases describing various behaviors associated with each of the Big Five dimensions. The instrument has a 5-point Likert response scale (1 = very inaccurate, 2 = inaccurate, 3 = neither accurate nor inaccurate, 4 = accurate, and 5 = very accurate).

Table 3 *ANOVA analysis of the IPIP*

	Mean	Std Dev	F	Sig
Agreeableness	43.47	7.730	2.001	.137
Conscientiousness	45.44	10.251	.188	.829
Extraversion	63.70	11.496	1.483	.229
Neuroticism	88.59	13.311	.456	.635
Openness/Intellect	49.88	12.666	3.688	*.026

*indicates significance at the p<.05 level

Details of the Analysis and the Results

Hypothesis 1 looked at the five personality traits between CCs and Non-CCs to ascertain if there were statistically significant differences between these personality traits to account for why some clinicians are able to work with clients in crisis (suicidal, psychotic, traumatized, extreme emotional dysregulation) consistently, while others

prefer to not work with them and refer them to CCs. Hypothesis 2 looked at three personality traits in particular that were deemed to be the most important when working with clients in crisis (Neuroticism, Openness/Intellect, and Conscientiousness) and compared these traits between CCs and former-CCs. To preview, the only trait that returned as statistically significant was Openness/Intellect between Non-CCs and Current CCs. The Non-CC group had statistically significant higher Openness/Intellect scores.

Once the data were separated into the three categories of participants (Current CC, Non-CC, and Former CC), a MANOVA analysis was conducted to assess statistical differences in personality factors across groups. MANOVA analyses assess differences across groups on several dependent variables simultaneously. If the observed differences are bigger than can be expected by chance, there will be statistical significance (Hopkins, 2000).

The MANOVA test revealed a marginally statistically significant difference in personality factors across the three groups ($F(10) = 1.81$, $p = .057$). ANOVA analyses were then conducted to find where the significance existed for each of the five personality traits.

Table 3 presents the analysis, which shows that there is a statistically significant result in the trait of Openness/Intellect ($F(183) = 2.49$, $p = .014$). T-tests were conducted between the groups of Non CC (M = 55.18, SD = 10.56) vs. Current CC (M = 49.88, SD = 12.67); t(183) = 1.52, p = .13, Former CC (M = 53.20, SD = 9.24) vs. Current CC (M = 49.88, SD = 12.67); t(111) = 1.54, p = .13, and Non-CC (M = 55.18, SD = 10.56) vs. Former CC (M = 53.20, SD 9.24); t(183) = 2.49, p = .01 to determine which groups were significantly different. As revealed by the *t*-test analyses, the Non-CC group has

significantly higher Openness/Intellect scores than the Former CC group. No other differences approached significance amongst either the groups or the personality traits. In hypothesis 1, the belief was that there would be a statistical significance between the five personality traits of Current CC and those of the Non-CC groups and the Former CC groups. In order to test this hypothesis, a one-way between subjects ANOVA was conducted to compare the personality types between the three groups. The results of this test show there was a significant effect on Openness/Intellect scores at $p<.05$ level for the three conditions [$F(2, 263) = 3.69$, $p = .026$].

Hypothesis 2 surmised that the Current CCs and the Former CCs would have a statistically significant difference between the three specific personality traits of Neuroticism, Openness/Intellect and Conscientiousness. In order to test this hypothesis, a one-way between subjects ANOVA was conducted to compare the three personality types between the two groups. The results of this analysis reveal there was no significant effect on the three traits. As Openness/Intellect was significantly different in Hypothesis 1, a *t* test analysis was conducted. This analysis also showed no significance at the $p<.05$ level [$t(111) = 1.54$, $p = .126$].

Neither of these hypotheses was fully supported by the data. Overall, the three groups did not score differently for the personality traits. The Current and Former CCs also did not score differently for the personality traits. The Current and Former CCs also did not score differently for the Neuroticism and Conscientiousness traits; however, there was a difference for the Openness/Intellect traits, which partially supports Hypothesis 2.

Conclusion

This chapter presented all data relevant to the two research questions and the proposed hypothesized relationship outlined and discussed in Chapter 1. Using the SPSS software program, the collected data were analyzed from the sample population of 266 Current, Former, and Non-CC clinicians who were members of the OBLPCT. It was hypothesized that Current CCs would show a significant difference in personality traits compared to the Former or Non-CC groups, but this was not supported. Only the Non-CC and Former CC groups showed any significant difference in personality traits and this was only on the trait of Openness/Intellect.

Chapter 5 discusses the results, conclusions, and recommendations based on the current study. In addition, the limitations of this study are examined. The chapter will also discuss the implications of the study for counseling professionals and their employers. Finally, recommendations for future research as it relates to the findings and limitations of this study are examined.

CHAPTER 5. RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

This chapter includes a discussion of major results obtained from the statistical analyses outlined in Chapter 4, in the context of the hypotheses and current research. First, I present a summary of the results of the study, including a discussion of its effectiveness in addressing the two research questions. Next is a discussion of the characteristics of the sample of crisis clinicians and their responses to the personality test and demographic questions. In the third section, I provide an overview of possible implications and limitations of the results from this study as well as suggestions for future research.

Summary of the Results

The purpose of this study was to determine what factors keep crisis clinicians in the field of crisis work. Crisis clinicians (CCs) are exposed to clients who are suicidal, traumatized, psychotic, and in extreme and dire emotional straits. The CC must navigate not only the clinical content of the experience with the client while maintaining rapport, but also negotiate the laws, ethics, and safety needs that are a big part of the work. In order to determine how to help CCs do this consistently time after time while remaining confident, able to maintain good rapport, and make appropriate decisions, required that we determine if this is an inherent personality factor, or if it is merely the product of good education and training. This study used a 14-item demographic Information Form and the 120-item International Personality Item Protocol (IPIP) to answer these questions:

Research Question 1: Is the CC group mean score of the measured values of Neuroticism, Extraversion, Openness/Intellect, Agreeableness, and Conscientiousness personality traits as measured by the IPIP significantly different than in the Non-CC group?

Research Question 2: In the CC group is there a statistically significant difference in the three specific personality traits of Neuroticism, Openness/Intellect, and Conscientiousness as measured by the IPIP than in the Former CC group?

Based on a review of the current research on personality traits and crisis counselors, I formulated two hypotheses to be tested in the study. *Hypothesis 1* addressed the levels of personality traits between CCs and Non-CCs with the belief that CCs would have lower levels of Neuroticism and higher levels of Agreeableness, Openness/Intellect, Conscientiousness, and Extraversion than their Non-CC counterparts. *Hypothesis 2* addressed the levels of three personality traits in particular (Neuroticism, Openness/Intellect, and Conscientiousness) between Former CCs and Current CCs. The belief was that Former CCs would have higher Neuroticism and lower Openness/Intellect and Conscientious levels of these three traits than the Current CCs.

Hypothesis 1 was proposed to determine why certain clinicians work well with clients in crisis (suicidal, psychotic, severe emotional dysregulation) and do this consistently when many other clinicians reported feeling high levels of stress and secondary trauma from these experiences. The results from the study show no significant difference between the three groups in several of the domains, including age, gender, training in graduate school and post graduate training for working with clients in crisis. There was a significant difference between the groups in the domain of compassion

fatigue/burnout. The Current CC group and the Non-CC group had significant levels of burnout although they were not statistically different from each other. Only the former CC group had no statistical significance for compassion fatigue/burnout, which is a surprising finding, as one would assume that clinicians would get burned out by working with such a high risk population. One of the factors researched was the low level of training in crisis received in graduate and post-graduate training programs. Multiple studies have been conducted that show the majority of clinicians graduating from graduate programs have had little to no formal suicide/crisis/trauma assessment training (Bongar & Harmatz, 1989; Dexter-Mazza, 2004; Kleespies, 1993; Kleespies et al., 1993; Knox et al., 2006, Munroe, 1995; and Voss Horrell et al., 2011). As a result of these studies, Munroe (1995) suggests that educators and internship supervisors have a "Duty to Train", meaning not only should they "be concerned about warning candidates of the potential harm of being exposed to [clients in crisis and] trauma, but that [they] should also train them how to cope with this exposure" (p. 215). What was encouraging to find in the results of this study was that the majority of the participants received graduate training (76%) and even more received training in their post-graduate career (94%) in working with individuals in crisis. It is unknown at this time if the majority of the clinicians who responded to this survey were educated in Oregon, as location of graduate school was not asked, but it can be assumed that most clinicians tend to do their graduate degrees close to where they live. It was noted in conducting this research that only 40-50% of graduate programs provide crisis training (Cramer et al. 2013). This suggests that schools in Oregon do a much better than average job of educating their students in crisis behavior.

Hypothesis 2 was proposed in order to determine what causes CCs to leave the profession. It was assumed that Former CCs primarily consisted of clinicians who weren't suited due to their personality traits to feel successful in this profession. The three traits of Neuroticism, Openness/Intellect, and Conscientiousness were specifically looked at due to their high correlation to working in this field. This hypothesis was determined to be unfounded in this study. This does not necessarily mean these hypotheses were incorrect, only that the data in this particular study did not show evidence. It would have been more effective to determine in hypothesis 2, for example, if more emphasis was placed on asking people who were Former CCs how long they worked in the field of crisis counseling to determine if they left the field because of not being suited, or if the job was changed due to leaving a work circumstance to go to a different position or to retirement.

Discussion of the Results

The selected participants were all members of the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT). The invitation was mailed to 2015 potential participants and they were invited to log onto an online survey through Survey Gizmo. The study was open for two months between April 17, 2013 and June 19, 2013.

The following is a description of the sample of 266 clinicians who are members of the OBLPCT. There were 32 Current CCs, 85 Former CCs, and 153 Non-CCs for a total sample of 266 participants, which represented a 13% return rate of the total of 2015 invited. Although this was a large enough sample based on the power analysis, this is a disappointing response rate to fully ascertain what was hypothesized. As I am a part of

this population and noted having difficulty receiving the invitation/reminders, it is likely that many of the potential participants did not receive the invites due to high spam filtering at their work environments. The initial invite and two reminder emails were sent from Survey Gizmo directly and a final email reminder was emailed from my work email. This final email was sent over a several day period due to limitations of the email system allowing only limited numbers of emails to be sent per day. Thirty-four participants responded to this last email, again suggesting that spam filtering for the Survey Gizmo site was partially responsible for the low return rate.

While the number is disappointing, the ratio of CCs to Non-CCs was fairly even considering the CC population is a fairly low number of the total of all mental health clinicians. There were 153 non-CCs and 113 total CCs (32 current and 81 former). It is possible that potential participants misunderstood the nature of this study and felt it didn't apply to them unless they were CCs and thus did not respond.

While gender was not considered a factor in this study, the represented sample is consistent with the industry standard of more females than males in the profession. There were 207 female vs. 59 male participants in this study. As discussed above, the majority of the participants received training in their graduate programs for working with clients in crisis (76%) and even more in their post-graduate career (94%), which is far above the industry standard of 40-50% of most graduate programs (Bongar & Harmatz, 1989). Of concern for most in the counseling profession regardless of job placement is risk for burnout. A significant proportion of the participants reported symptoms of compassion fatigue/burnout (75% for Non-CC, 58% for Former CC and 84% for Current CC), yet 94% of the total report job satisfaction. There could be many factors that were

contributing to this job satisfaction, which were not a focus of this study and thus not asked. One factor that was asked and is significant is that 86% access good support and supervision. This is encouraging as burnout can cause clinicians to be less effective in their jobs and even leave the profession.

Due to the limited number of responses to this survey, it will be difficult to extrapolate these results to the overall larger population of licensed clinicians. It is possible that the only ones who responded to the survey were individuals with personality traits that were more like the ones hypothesized for the CC population. This study hypothesized that CCs who were successful in their jobs would have lower levels of Neuroticism and higher levels of Agreeableness, Conscientiousness, Extraversion, and Openness/Intellect. As discussed in Chapter 2, individuals with high levels of Neuroticism tend to be more negative in their outlook on life and as such tend to experience life events more negatively than those with low levels of Neuroticism. It is unlikely that those who have a negative outlook would respond to a survey request. The other four traits were hypothesized to be more positive in CCs, as individuals with high levels of Agreeableness tend to have greater motivation to achieve interpersonal intimacy and have higher levels of well-being and life satisfaction. Those with high levels of Conscientiousness respond to both intrinsic (respect, recognition feelings of personal accomplishment) and extrinsic (pay, promotions) rewards. Knowing they are contributing to the improvement of the field by their participation would likely appeal to their intrinsic motivation to participate. Individuals who are high in Extraversion tend to experience more positive emotions in relation to life events, spend more time in social situations and find work relationships more rewarding. This willingness to reach out to others also

likely improves their likelihood to respond to such surveys. Individuals high in Openness/Intellect tend to be artistic and creative in science. These individuals are more likely to be supportive of peers who are conducting surveys (Judge, et al., 2002). As there were so few participants, their response rate to the five factors showed no statistical significance other than on the Openness/Intellect factor, which showed a statistical significance for only the Non-CC group. Which suggests that as mentioned above, the Non-CCs that participated tended to have higher levels of Openness/Intellect and thus were the ones that responded to the survey request. One can perhaps surmise from these results that the Non-CCs that responded would have made good CCs especially since so many of them report having worked with clients in crisis. However, due to the overall low numbers that responded, this cannot be proved in this study.

Discussion of the Conclusions

While this research had strong potential to determine if certain personality traits were important in determining which clinicians are better suited to work consistently with clients in crisis as CCs do, the disappointing level of participation (13% return) for this study meant that not enough participants were included to make any definitive predictions. Both research questions were found to be unsubstantiated in this study. This study was helpful as it showed that many other factors needed to be included to get a more complete picture of the factors that contribute to being a successful Crisis Clinician. This study should have included information on where the graduate degrees were obtained as those who participated had high levels of graduate and post-graduate training in working with crisis clients, which was higher than the researched rate of 40-50%. It is

possible that Oregon has looked at the research and incorporated this important training in their graduate programs. One factor that should have been followed up more closely was the effect of secondary traumatic stress on clinicians. Especially to see if that was a factor in people leaving the crisis counseling profession. Participants were asked if they left the field of crisis counseling due to the nature of the work and 5% indicated this was the case, which leaves 95% leaving for other reasons. Participants reported they do well with accessing supervision (86%) and it would have been good to see how much of a mitigating factor this was in terms of burnout as opposed to other self-care activities since 94% of participants reported liking their jobs. A question that needed clarity was if their current primary job title was as a crisis counselor. Many counselors work in crisis centers as a second job and thus it is not the primary job title, but rather the secondary job title. Another question that appeared to be confusing was "Have you done any crisis counseling (work closely with suicidal, psychotic, traumatized, or extreme emotionally dysregulated clients)?" Ninety-seven percent of the participants answered this affirmatively although only 113 had any experience as crisis counselors. There was an additional question "Have you worked at any time with crisis clients (suicidal, psychotic, traumatized, in extreme emotional dysregulation), even if only minimally?" that was designed to see if the participants had been exposed to crisis clients but not necessarily worked in the crisis field. This question appears to have been understood as only two participants of the 266 reported never having worked with a client in crisis. Overall the study questions appear to have been understood by the participants.

Limitations

There were several limitations of the present study that prevented further examination of the research questions. The biggest challenge was the limited number of responses. It is unclear whether this was related to the materials received by the potential participants that may have been off-putting for some reason, or if the invitation even made it to all potential participants as a result of spam filtering pulling the invitations before they could be received. In order to keep this study manageable time-wise for participants, additional helpful questionnaires for factors such as secondary traumatic stress, general stress levels, burnout symptomology, and self-care interventions were not asked. All of these factors would have added an interesting layer to the analysis, especially since there are so few studies on crisis clinicians. Another factor that might have inhibited the responses is that the job responsibility of the CC is different from agency to agency and county to county throughout the state. Some CCs only manage a crisis line while others handle a variety of situations and manage acute crises in office settings, on scene with law enforcement, and in hospital emergency departments. Each situation will have its own level of stressors attached to it. If people mistakenly identified this study as only being about CCs, that may have limited it dramatically and kept many from participating and realizing that a Non-CC group was necessary to make determinations from the data.

One limitation of the personality test is that the responses are meant to be a snapshot of the individual taking it at a set moment in time. Factors can affect how an individual answers questions such as “Get angry easily”, “Experience my emotions intensely”, etc. as some of these statements are based on emotions that may be affected

by what is happening in the individual's life at the time the test in given.

As discussed, there was one question on the demographic questionnaire that appeared to be confusing ("Have you done any crisis counseling (work closely with suicidal, psychotic, traumatized, or extreme emotionally dysregulated clients)?") as 97% of the participants stating they had worked in crisis counseling. This question should have reflected that I was looking for clinicians who at any time in their career worked as crisis clinicians, as I asked at a later point how many had worked with clients in crisis, even if only minimally.

Recommendations for Future Research or Interventions

Several interesting ideas emerged from the current study as possible areas of future research. As discussed in the results, a high percentage of the participants reported receiving crisis training in both graduate and post-graduate placements. Determining if Oregon has a high incidence of training in their graduate programs for working with these types of clients and the fact that it does not appear to be a personality factor as determined by this study would be important to determine so the rest of the graduate counseling programs in the United States could see the benefit of including it in their programming. People's lives depend on finding a counselor in times of crisis that know how to handle the situation. If every counselor had this training prior to ever meeting with clients, it could save a significant number of lives.

Determining what factors led to the participants enjoying their job despite fairly high levels of burnout would be interesting to study. What increases the compassion satisfaction of clinicians who work with individuals who are suicidal, psychotic, or

otherwise traumatized? What self-care interventions are utilized to keep CCs from succumbing to burnout? What role does supervision have for the CC? One factor that has been talked about extensively amongst my peers, is not finding out what happens to many of the people we work with. We often do not receive any follow-up information on clients for whom we've hospitalized or set up other resources. There were quite a few Former CCs in this study. Only 5% left the field due to the client issues, finding out the reasons behind the other 95% would be interesting and may prove to be a worthwhile study.

Conclusion

While the return rate of the responses was less than desired and the analysis did not show any significant results, the information that was obtained does provide an interesting picture. The Crisis Clinicians who participated had good training prior to embarking on their crisis careers. Despite working with such an intense and difficult population and experiencing symptoms of compassion fatigue/burnout, the majority of them have high job satisfaction. One of the initial questions at the start of this study was whether personality or training was what led to successful crisis careers. Due to the high reported level of training, it can be surmised from the results of this study that training was a mitigating factor in the success of those in this field. It is very clear from the results of this study that training is an important factor when working with such high-risk clients. There are very few studies that have been conducted on Crisis Clinicians. More studies need to be conducted to get a good picture of just how effective training is on this sub-field of the counseling profession.

REFERENCES

American Counseling Association (ACA) (2005). Code of Ethics. Retrieved June 1, 2013 from:http://www.counseling.org/Resources/aca-code-of-ethics.pdf

Bandura, A. (1994). Self-efficacy. In V. S. Ramachaudran (Ed.), *Encyclopedia of human behavior.* New York: Academic Press, pp. 71-81.

Bandura, A. (1997). *Self-Efficacy: The exercise of control.* New York: W. H. Freeman and Company.

Barrick, M. R., & Mount, M. K. (2005). Yes, personality matters: Moving on to more important matters. *Human Performance,* 18(4), 359-372.

Belmont Report (1974). The Belmont Report retrieved June 1, 2013 from: http://www.irb.vt.edu/pages/guidelines.htm

Bongar, B., & Harmatz, M., (1989). Graduate training in clinical psychology and the study of suicide. *Professional Psychology: Research and Practice,* 20(4), 209-213.

Boslaugh, S., & Watters, P. W., (2008). *Statistics in a nutshell: A desktop quick reference*. Sebastopol, CA: O'Reilly.

Buchanan, T., Johnson, J. A., & Goldberg, L. R. (2005). Implementing a five-factor personality inventory for use on the internet. *European Journal of Psychological Assessment*, 21(2), 115-127.

Campbell, C. D., Campbell, D. L., O'Friel, M. & Kennedy, J. (2009). Practicum training in emergency consultation in a rural hospital. *Training and Education in Professional Psychology.* 3(3), 177-183.

Chadwick, G. L., & Dunn, C. M. (2000). Institutional Review Boards: Changing with the times? *Journal of Public Health Management and Practice*, 6: 19-27.

Chemtob, C. M., Hamada, R. S., Bauer, G., Torigoe, R. Y., & Kinney, B. (1988). Patient suicide: Frequency and impact on psychologists. *Professional Psychology: Research and Practice,* 19(4), 416-420.

Colorado State University (CSU) (2012). Advantages and disadvantages of the survey method. Retrieved August, 26, 2012 from: http://writing.colostate.edu/guides/research/survey/com2d1.cfm

Costa, P. T. & McCrae, R. R. (1992). Revised NEO Personality Inventory (NEO-PI-R) and NEO Five-Factor Inventory (NEO-FFI): Professional manual. Odessa, FL: Psychological Assessment Resources.

Cramer, R. J., Johnson, S. M., McLaughlin, J., Rausch, E. M., & Conroy, M. A. (2013). Suicide risk assessment training for psychology doctoral programs: Core competencies and a framework for training. *Training and Education in Professional Psychology,* 7(1), 1-11.

Cummins, P. N., Massey, L., & Jones, A., (2007, Spring). Keeping ourselves well: Strategies for Promoting and Maintaining counselor wellness. *Journal of Humanistic Counseling, Education and Development.* 46, 35-49.

Dexter-Mazza, E., (2004, Spring/Summer). The lack of graduate school training in suicide assessment and management. *Section on Clinical Emergencies and Crises:* American Psychological Association. Retrieved July 21, 2012 from http://www.apa.org/divisions/div12/sections/section7/news/sp04/lack.html

Donnellan, M. B., Oswald, F. L., Baird, B. M., & Lucas, R. E., (2006). The mini-IPIP scales: Tiny-yet-effective measures of the Big Five factors of personality. *Psychological Assessment*, 18(2), 192-203.

Ellis, T. E., & Patel, A. B., (2012). Client suicide: What now? *Cognitive and Behavioral Practice,* 19, 277-287.

Figley, C. (1993). Compassion stress and the family therapist. *Family Therapy News.* 1-8.

Figley, C. (1995). *Compassion fatigue: Secondary trauma stress disorder in those who treat the traumatized.* New York: Brunner & Routledge.

Figley, C. R., (2003). Compassion fatigue: An introduction. Retrieved July 19, 2012 from http://www.giftfromwithin.org/html/What-is-Compassion-Fatigue-Dr-Charles-Figley.html

Figley, C. R., (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *JCLP/In Session: Psychotherapy in Practice,* 58(11), 1433-1441.

Fowler, J. C., (2012). Suicide risk assessment in clinical practice: Pragmatic guidelines for imperfect assessments. *Psychotherapy* 49(1), 81-90.

Ghahramanlou, M. & Brodbeck, C. (2000). Predictors of secondary trauma in sexual assault trauma counselors. *International Journal of Emergency Mental Health* 2(4), 229-240.

Goldberg, L. R., (1992). The development of markers for the Big-Five factor structure. *Psychological Assessment*, 4, 26-42.

Goldberg, L. R., Johnson, J. A., Eber, H. W., Hogan, R., Ashton, M. C., Coninger, C. R., & Gough, H. G. (2006). The international personality item pool and the future of public-domain personality measures. *Journal of Research in Personality*, Vol. 40, 84-96.

Grad, O. T., Zavasnik, A., & Groleger, U. (1997). Suicide of a patient: Gender differences in bereavement reactions of therapists. *Suicide and Life Threatening Behaviors,* 27(4), 379-386.

Gravetter, F. J. & Wallnau, L. B. (2009). *Statistics for the Behavioral Sciences*. Belmont, CA: Wadsworth

Guenole, N., & Chernyshenko, O. S. (2005, July). The suitability of Goldberg's Big Five IPIP personality markers in New Zealand: A dimensionality, bias, and criterion validity evaluation. *New Zealand Journal of Psychology.* 34(2), 86-96.

Gulfi, A., Dransart, D. A. C, Heeb, J-L, and Gutjahr, E. (2010). The impact of patient suicide on the professional reactions and practices of mental health caregivers and social workers. *Crisis,* 31(4), 202-210.

Hopkins, W. G., (2000). A new view of statistics: T Test and one-way ANOVA. Retrived 11/21/12 from: http://www.sportsci.org/resource/stats/ttests.html

International Personality Item Pool (IPIP) (2012). Index of IPIP scales. Retrieved October 12, 2012 from http:///www.ipip.ori.org

Jacobson, J. M., Ting, L., Sanders, S., and Harrington, D. (2004). Prevalence of and reactions to fatal and nonfatal client suicide behavior: A national study of mental health social workers. *Omega* 49(3), 237-248.

Jobes, D. A., (1995). The challenge and the promise of clinical suicidology. *Suicide and Life Threatening Behavior* 25, 437-449.

John, O. P., Naumann, L. P., & Sotto, C. J., (2008). Paradigm shift to the integrated Big-Five trait taxonomy. In O. John, R. Robbins, & L. Pervin (Eds.), *Handbook of personality*, (pp. 114-158). New York, NY: Guilford Press.

Johnson, J. A. (2006). The IPIP–NEO. Retrieved March 22, 2013 from http://www.personal.psu.edu/faculty/j/5/j5j

Johnson, J. A. (2012). IPIP descriptions. Retrieved October 13, 2012 from http://www.personal.psu.edu/faculty/j/5/j5j/IPIPNEOdescriptions.html

Judge, T. A., Heller, D., & Mount, M.K. (2002). Five-factor model of personality and job satisfaction: A Meta-analysis. *Journal of Applied Psychology* 87(3), 530-541.

Karver, M. S., Tarquini, S. J., & Caporino, N. E. (2010). The judgment of future suicide-related behavior. *Crisis*, 31(5), 272-280.

Kleespies, P. M. (1993). The stress of patient suicidal behavior: Implications for interns and training programs in psychology. *Professional Psychology: Research and Practice,* 24(4), 477-482.

Kleespies, P. M., Deleppo, J. D., Gallagher, P. L. & Niles, B. L. 1999). Managing suicidal emergencies: Recommendations for the practitioner. *Professional Psychology: Research and Practice.* 30(5), 454-463.

Kleespies, P. M., & Dettmer, E. L., (2000). The stress of patient emergencies for the clinician: Incidence, impact, and means of coping. *Journal of Clinical Psychology*, 56(10), 1353-1369.

Kleespies, P. M., Penk, W. E., & Forsyth, J. P. (1993). The stress of patient suicidal behavior during clinical training: Incidence, impact, and recovery. *Professional Psychology: Research and Practice*, 24, 293-303.

Knox, S., Burkard, A., Jackson, J. A., Schaack, A. M., & Hess, S. A., (2006, October). Therapists-in-training who experience a client suicide: Implications for supervision. *Professional Psychology: Research and Practice,* 37(5), 547-557.

Kruger, J. & Dunning, D. (1999). Unskilled and unaware of it: How difficulties in recognizing one's own incompetence lead to inflated self-assessments. *Journal of Personality and Social Psychology*, 77(6), 1121-1134.

McAdams, D. P. & Pals, J. L. (2006). A new Big Five: Fundamental principles for an integrative science of personality. *American Psychologist* 61(3), 204-217.

Mertler, C. A., & Vannatta, R. A., (2005). *Advanced and multivariate statistical methods: Practical application and interpretation* (3rd ed.). CA: Pyrczak Publishing.

Munroe, J. (1999). Ethical issues associated with secondary trauma in therapists. In B. H. Staff (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed., pp. 211-229). Lutherville, MD: Sidran Press.

Nardi, P. M. (2013). *Doing survey research: A guide to quantitative methods*. (3rd ed.). Paradigm Publishers: Boulder, CO.

National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. (1974). Retrieved October 30, 2012 from http://www.hhs.gov/ohrp/archive/national commission.html

Nelson, C., Johnston, M., & Shrivastava, A. (2010). Improving risk assessment with suicidal patients. *Crisis*, 31(5), 231-237.

Niles, R. (2012). T tests. Robert's Stat Guide. http://www.robertniles.com/stats/tscore.shtml.

Oordt, M. S., Jobes, D. A., Rudd, M. D., Fonseca, V. P., Runyan, C. N., Stea, J. B., Campise, R. L., & Talcott, G. W., (2005). Development of a clinical guide to enhance care for suicidal patients. *Professional Psychology: Research and Practice,* 36(2), 208-218.

Overholser, J. C. (1995). Treatment of suicidal patients: A risk-benefit analysis. *Behavioral Sciences and the Law*, 13, 81-92.

Packman, W. L., O'Connor Pennuto, T., Bongar, B., & Orthwein, J. (2004). Legal issues of professional negligence in suicide cases. *Behavioral Sciences and the Law,* 22, 697-713.

Schmitz, Jr., W. M., Allen, M. H., Feldman, B. N., Gutin, N. J., Jahn, D. R., Kleespies, P. M., Quinnett, P., and Simpson, S. (2012, June). Preventing suicide through improved training in suicide risk assessment and care: An American Association of Suicidology Task Force report addressing serious gaps in U. S. mental health training. *Suicide and Life Threatening Behavior*, 42(3), 292-304.

Smith, A. R., Witte, T. K., Teale, N. E., King, S. L., Bender, T. W., & Joiner, T. E. (2008). Revisiting impulsivity in suicide: Implications for civil liability of third parties. *Behavioral Sciences and the Law,* 26, 779-797.

Socha, A., Cooper, C. A., & McCord, D. M. (2010). Confirmatory factor analysis of the M5-50: An implementation of the International Personality Pool Item set. *Psychological Assessment,* 22(1), 43-49.

Spiegelman, J. S., & Werth, Jr., J. L. (2005). Don't forget about me: The experiences of therapists-in-training after a client has attempted or died by suicide. *Women & Therapy*, 28(1), 35-57.

Stamm, B. H. (2009). Professional quality of life: Compassion satisfaction and fatigue. Version 5 (PRoQOL). Retrieved from http://www.proqol.org

Stamm, B. H. (2010). *The Concise ProQOL manual.* Retrieved from http://www.proqol.org

Stroul, B. A. (1993). *Psychiatric crisis response systems: A descriptive study.* Darby, PA: Diane Publishing Co.

Talbot, A., Manton, M., & Dunn, P. J. (1992). Debriefing the debriefers: An intervention strategy to assist psychologists after a crisis. *Journal of Traumatic Stress*, 5(1), 45-62.

Teglassi, H., Simcox, A. G., & Kim, N-Y. (2007). Personality constructs and measures. *Psychology in the Schools*, 44(3), 215-228.

Texas State Auditor's Office (TSAO) (May, 1995). *Methodology manual*. Retrieved online August 31, 2012 from: http://www.sao.state.tx.us/resources/Manuals/Method/data/10DESCSD.PDF

Thalmayer, A. G., Saucier, G., & Eigenhuis, A. (2011). Comparative validity of brief to medium-length Big Five and Big Six personality questionnaires. *Psychological Assessment,* 23(4), 995-1009.

Ting, L., Jacobson, J. M., Sanders, S. (2011, October). Current levels of perceived stress among mental health social workers who work with suicidal clients. *Social Work,* 56(4), 327-336.

Ting, L., Sanders, S., Jacobson, J. L., and Power, J. R. (2006, October). Dealing with the aftermath: A qualitative analysis of mental health social workers' reactions after a client suicide. *Social Work,* 51(4), 329-341.

Urbani, S., Smith M. R., Clebornene, D. M., Smaby, M. H., Torres-Rivera, E. & Crews, J. (2002, December). Skills-based training and counseling self-efficacy. *Counselor Education and Supervision.* 42, 92-106.

Veilleux, J. C. (2011). Coping with client death: Using a case study to discuss the effects of accidental, undetermined, and suicidal deaths on therapists. *Professional Psychology: Research and Practice,* 42(3), 222-228.

Voss Horrell, S. C., Holohan, D. R., Didion, L. M., & Vance, G. T. (2011). Treating traumatized OEF/OIF veterans: How does trauma treatment affect the clinician? *Professional Psychology: Research and Practice,* 42(1), 79-86.

Wurst, F. M., Kunz, I., Skipper, G., Wolfersdorf, M., Beine, K. H., & Thon, N. (2011). The therapist's reaction to a patient's suicide. *Crisis*, 32(2), 99-105.

Yassen, J. (1995). Preventing secondary traumatic stress disorder. In C.R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* (pp.178-208). Levittown, PA: Brunner/Mazel.

APPENDIX A. STATEMENT OF ORIGINAL WORK

Academic Honesty Policy

Capella University's Academic Honesty Policy (3.01.01) holds learners accountable for the integrity of work they submit, which includes but is not limited to discussion postings, assignments, comprehensive exams, and the dissertation or capstone project.

Established in the Policy are the expectations for original work, rationale for the policy, definition of terms that pertain to academic honesty and original work, and disciplinary consequences of academic dishonesty. Also stated in the Policy is the expectation that learners will follow APA rules for citing another person's ideas or works.

The following standards for original work and definition of *plagiarism* are discussed in the Policy:

> Learners are expected to be the sole authors of their work and to acknowledge the authorship of others' work through proper citation and reference. Use of another person's ideas, including another learner's, without proper reference or citation constitutes plagiarism and academic dishonesty and is prohibited conduct. (p. 1)
>
> Plagiarism is one example of academic dishonesty. Plagiarism is presenting someone else's ideas or work as your own. Plagiarism also includes copying verbatim or rephrasing ideas without properly acknowledging the source by author, date, and publication medium. (p. 2)

Capella University's Research Misconduct Policy (3.03.06) holds learners accountable for research integrity. What constitutes research misconduct is discussed in the Policy:

> Research misconduct includes but is not limited to falsification, fabrication, plagiarism, misappropriation, or other practices that seriously deviate from those that are commonly accepted within the academic community for proposing, conducting, or reviewing research, or in reporting research results. (p. 1)

Learners failing to abide by these policies are subject to consequences, including but not limited to dismissal or revocation of the degree.

Statement of Original Work and Signature

I have read, understood, and abided by Capella University's Academic Honesty Policy (3.01.01) and Research Misconduct Policy (3.03.06), including the Policy Statements, Rationale, and Definitions.

I attest that this dissertation or capstone project is my own work. Where I have used the ideas or words of others, I have paraphrased, summarized, or used direct quotes following the guidelines set forth in the APA *Publication Manual*.

Mentor name and school	Brianna Eiter, Ph.D. Capella University
Learner signature and date	Stacey A. Caraballo 10-7-13