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The effectiveness of Dialectical Behavioral Therapy in the reduction of suicidal ideation and suicidal behavior in individuals with borderline personality.

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RESUMEN

La Terapia Dialéctica Conductual es un tratamiento basado en la terapia cognitiva diseñada específicamente para individuos con trastorno de personalidad limítrofe. Los individuos con este trastorno de personalidad experimentan altas tasas de ideación suicida y comportamientos suicidas que pueden ser mortales. Este enfoque de tratamiento se divide en cuatro módulos: mindfulness, efectividad interpersonal, tolerancia a la angustia y regulación de las emociones. El propósito de este estudio fue examinar la efectividad de la Terapia Dialéctica Conductual para reducir la frecuencia e intensidad de la ideación suicida y las conductas suicidas en individuos con trastorno de personalidad limítrofe. Los participantes fueron reclutados de universidades, clínicas y hospitales. Los individuos participaron en sesiones semanales de terapia individual y grupal durante un año. Se utilizo la Colombia-Suicide Severity Rating Scale para medir la ideación suicida, el comportamiento suicida y la mortalidad de los participantes. La escala se utilizo para medir los participantes tres veces en un periodo de doce meses: antes del tratamiento, seis meses después del tratamiento y al final del tratamiento. Finalmente, se espera que el tratamiento tenga resultados significativos en la reducción de la frecuencia e intensidad en que los participantes experimentan la ideación y comportamientos suicidas.

*Palabras clave***:** Terapia Dialéctica Conductual, ideación suicida, comportamientos suicidas, personalidad limítrofe.

ABSTRACT

Dialectical Behavior Therapy is a cognitive based treatment designed specifically for individuals with Borderline Personality Disorder. Individuals with this type of personality disorder experience high rates of suicidal ideation and suicidal behaviors which can be fatal. This treatment approach is divided into four different modules: mindfulness, interpersonal effectiveness, distress tolerance and emotion regulation. The purpose of this study was to examine the effectiveness that Dialectical Behavioral Therapy has on reducing the frequency and intensity of suicidal ideation and suicidal behaviors in individuals with diagnosed Borderline Personality Disorder. The participants were recruited from universities, clinics and hospitals. The individuals participated in weekly individual and group sessions for a period of one year. The Columbia-Suicide Severity Rating Scale was used to measure suicidal ideation, suicidal behavior and lethality. The scale was used to measure participants three times in a period of twelve months: before treatment, six months into treatment and at the end of treatment. Finally, it is expected that the treatment will have significant results in the reduction of the frequency and intensity that participants experience suicidal ideation and suicidal behaviors.

Keywords: Dialectical Behavioral Therapy, suicidal ideation, suicidal behaviors, Borderline Personality Disorder

RESEARCH PROPOSAL

INTRODUCTION

A personality disorder, as defined by the American Psychiatric Association is when a person's way of thinking, feeling and behaving differs from cultural expectation, and causes distress or problems in the individuals functioning and lasts over time (2018). Personality is what makes each person different, and is influenced by experiences, their environment as well as characteristics that have been inherited. There are ten different types of personality disorders currently identified in the Fifth Edition of the Diagnostic and Statistical Manual(DMS-V). The different types are divided into three different clusters which are based on their resemblance (Barlow & Durand, 2015). It is estimated that 10% and 13% of the world's population suffers from some type of personality disorder (Cleveland Clinic , 2018).

The first cluster is called cluster A, which are the "odd or eccentric disorders" (Barlow & Durand, 2015). In this cluster there are three personality disorders: paranoid personality, schizoid personality, and schizotypal personality (Barlow & Durand, 2015). The second cluster is cluster B, which are called the "dramatic, emotional, or erratic disorders" (Barlow & Durand, 2015). There are four personality disorders in cluster B: antisocial personality, borderline personality, histrionic personality, and narcissistic personality (Barlow & Durand, 2015). Finally, the last cluster is called cluster C, which contains the "anxious or fearful disorders" (Barlow & Durand, 2015). There are three disorders in this cluster: avoidant personality, dependent personality, and obsessive-compulsive personality (Barlow & Durand, 2015).

Borderline Personality Disorder is part of cluster B and is characterized by a pattern of instability in the individuals interpersonal relationships, self-image, affect, and impulse control (Barlow & Durand, 2015). This personality disorder is thought to have a variety of probable etiologies which have been studied though different approaches, such as the

psychodynamic and behavioral approach, as well as psychosocial and structural ones. The psychosocial approach proposes that Borderline Personality Disorder may be due to childhood maltreatment or problems in attachment (Hooley & St. Germain, 2013). This personality disorder has a prevalence rate of 1.6% in one year period and a 5.9% prevalence rate in lifetime, it is also diagnosed more often in females than in males (Skodol, 2019).

Suicide, the act of killing oneself, and is often the result of depression or other mental illness. In the United States alone, suicide is the cause of death in about 2% of cases and is increasing in young people ages 15 to 24 (American Psychological Association, 2018). On the other hand, according to the World Health Organization around 800,000 people die of suicide worldwide each year (2019). Suicidal ideation in contrast is when an individual has thoughts about suicide. A survey conducted by the World Health Organization revealed that in a one year period the prevalence of suicidal ideation was approximately 2% and the life time prevalence was approximately 9%. They also found that individuals who have a history of suicidal ideation have a 33% chance of having a suicide attempt plan, and a 55% probability of ever attempting that plan (Schreiber & Culpepper, 2019). Suicidal behaviors are those actions in which individuals cause intentional bodily harm like self-mutilation in which they cut or burn themselves.

According to the Diagnostic and Statistical Manual Fifth Edition (DSM-V) the patterns of behavior that characterize Borderline Personality Disorder often begin in adolescence or in early adulthood, but the diagnosis is not permitted before the age of 18, as with all personality disorders with the exception of antisocial personality disorder (2013). Because of the criteria set in the Diagnostic and Statistical Manual Fifth Edition (DSM-V) this personality disorder is often hard to diagnose. There are nine different criteria and the individual must meet five or more of them to be diagnosed, but there are no specific nor required criteria that must be met. This makes the diagnosis difficult because each individual

may display different patterns of behavior and there is no time requirement for the presence of the symptoms.

There are a variety of treatment models that have been used to treat Borderline Personality Disorder, the most widely used are different types of psychotherapy. An individual may be treated through the use of "schema-focused therapy, mentalization-based therapy, systems training for emotional predictability and problem solving, transference-focused psychotherapy, medication, psychiatric management, self-care activities, and Dialectical Behavioral Therapy (DBT)" (Mayo Clinic, 2019).

The astonishing rates of suicide, suicidal ideation, and suicidal behavior, as well as the prevalence rates of personality disorders, especially Borderline Personality Disorder, have impacted the world and society enormously. The difficulty in the treatment of this disorder has led to a proposed alternative to confront this problem through the implementation of Dialectical Behavioral Therapy (DBT) as the standard treatment for Borderline Personality Disorder. Dialectical behavioral therapy is a type of psychotherapy that uses a cognitive behavioral approach which also emphasizes psychosocial aspects in treatment (Grohol, 2019). This therapy has three different components: it is support oriented, cognitive based, and collaborative (Grohol, 2019). The way in which this therapy is implemented is through weekly individual and group psychotherapy.

There are four modules to Dialectical Behavioral Therapy (DBT). The first is mindfulness, which means that the skills taught here are focused on teaching individuals to focus on the present in a calm way. The second module is interpersonal effectiveness, which teaches individuals skills to improve and cope with their interpersonal relationships. The third is distress tolerance, which helps individuals learn how to self sooth when their emotions are running high. The last module is emotion regulation skills, which is aimed at helping individuals learn to understand their emotions. This type of psychotherapy was developed by

Marsha Linehan in the late 1980's as a specific way to treat Borderline Personality Disorder (Schimelpfening, 2019). The way in which this therapy was developed means it specifically targets suicidal ideation, and therefore suicidal behavior and suicide itself.

The objective of this study is to evaluate if the implementation of Dialectical Behavioral Therapy as the standard treatment for individuals with Borderline Personality Disorder worldwide could reduce the rates of suicidal ideation, suicidal behavior, and completed suicide.

BACKGROUND

Borderline Personality Disorder

Borderline Personality Disorder is a serious personality disorder that causes a series of adverse consequences in individuals, their families, and society. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), Borderline Personality Disorder is defined as "a dominant pattern of unstable interpersonal relationships, self-image, and affects, as well as marked impulsivity that begins in early adulthood and is present in different contexts" (American Psychiatric Association, 2013). The main characteristics of Borderline Personality Disorder have been described are cognitive, behavioral, and interpersonal.

According to statistics Borderline Personality Disorder constitutes around 9.3% of psychiatric outpatients and approximately 20% of inpatients in mental health clinics (Skodol, 2019). The American Psychiatric Association has established a series of behaviors and actions that are commonly found in individuals with Borderline Personality Disorder. In the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) there are nine different criteria used to diagnose this disorder. An individual must meet at least five of these criteria to be diagnosed.

Individuals with Borderline Personality Disorder make frantic efforts to avoid real or imagined abandonment (Criteria 1). What this means is that individuals with this disorder are very sensible to what goes on around them. When they experience a fear of abandonment this may lead to inappropriate anger, because they have an intolerance of being alone. This could also lead them to impulsive actions such as suicidal behaviors or self-mutilation. The individuals have a pattern of unstable and intense relationships (Criteria 2). In many instances, these individuals tend to idealize those around them, but in an instant this can turn them into them devaluating these same individuals. This means they are prone to shifts in the way in which they view others. There may be an identity disturbance characterized by markedly and persistently unstable self-image or sense of self (Criteria 3). These individuals have sudden shifts in the ways in which they view themselves. Many times they tend to change how they view themselves, what they want to be and who they want to be. In certain instances their self-image is influenced greatly by their interpersonal relationships. In circumstances were they lack meaningful relationships they tend to feel inexistent (American Psychiatric Association, 2013).

Individuals with Borderline Personality Disorder display impulsivity in at least two areas that are potentially self-damaging (Criteria 4). Behaviors that these individuals tend to engage in are gambling, excessive spending, binge eating, substance abuse, unsafe sexual behavior or reckless driving. Individuals with this disorder display recurrent suicidal behavior, gestures or threats, and self-mutilating behavior (Criteria 5). These behaviors are often the reason that these individuals seek help. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) 8% to 10% of individuals with Borderline Personality Disorder die from suicide (2013). These behaviors usually occur as a result of separation or rejection as is discussed in criteria 1. Individuals with Borderline Personality Disorder may display affective instability that is due to a marked reactivity of

mood (Criteria 6). What this means is that they display intense moods like irritability or anxiety that can last for a few hours or up to a few days at a time. They can also exhibit intense and inappropriate anger or despair, which is often precipitated as a reaction to stressors from their interpersonal relationships (American Psychiatric Association, 2013).

Individuals may be troubled by chronic feelings of emptiness (Criteria 7). What this means is that in most situations these individuals are often bored, which causes them to constantly look for something to do. Individuals frequently express inappropriate, intense anger or have difficulty controlling their anger (Criteria 8). They can have frequent outbursts of anger, which can be sarcastic or bitter. Most times this is due to someone close to them being perceived as neglectful, uncaring or as abandoning them. But in most cases after this happens they tend to feel evil which changes their self-image. During periods of extreme stress, transient paranoid ideation or dissociative symptoms may occur (Criteria 9). In some cases depersonalization can occur, but the episodes are generally not severe enough or do not last enough time to give an individual another diagnosis. These can occur in response to real or imagined abandonment (American Psychiatric Association, 2013).

Suicide, Suicidal Behavior and Suicidal Ideation

It is important to differentiate between suicide, suicidal behavior, and suicidal ideation. Suicidal ideation is defined as "wanting to take ones own life or thinking about suicide" (Purse, 2019). There are two different types of suicidal ideation, passive and active. Passive suicidal ideation is when "an individual wishes they were dead, but do not actually make any plans to commit suicide" (Purse, 2019). Active suicidal ideation is when "an individual is not only thinking about suicide, but actually has a plan, method, and intends to commit suicide" (Purse, 2019). Suicidal behavior is any type of behavior that is done on purpose and could lead to death. There are a variety of behaviors that are seen as suicidal, the most common are cutting, burning or drug use. Suicidal behavior is present in many

psychiatric disorders, but in Borderline Personality Disorder it is recurrent and can be expected to appear in response to the individuals life events (Paris, 2006). The fact that it occurs in response to life events is what helps distinguish Borderline Personality Disorder from other mood disorders. Suicidal behaviors can also be referred to as "deliberate self-harm, which is any type of self-injurious behavior including suicide attempts and non-suicidal self-injurious behaviors, that are those were the individual does not have an intent to die" (Turecki & Brent, 2016). Suicide is the act of taking one's own life. It is something that occurs in all cultures as well as age groups. According to the World Health Organization, close to 800,000 people die every year because of suicide making it a global problem (2019). Suicidal ideation often leads to suicidal behavior and in some cases to completed suicide.

The Problem

Worldwide there is an astonishing prevalence of suicide, suicidal behavior, and suicidal ideation, as well as personality disorders. An estimated 10% to 13% of the population suffers from some type of personality disorder (Cleveland Clinic , 2018). In the general adolescent population it is estimated that around 3% of the population suffer from Borderline Personality Disorder (Guilé, Boissel, Alaux- Cantin, & de La Riviére, 2018) and in the general population it is estimated to be around 1.6% (Chapman, Jamil, & Fleisher, 2019). It is also important to note that 20% of inpatients in mental health facilities have been diagnosed with Borderline Personality Disorder (Chapman, Jamil, & Fleisher, 2019).

Suicide is one of the leading causes of death worldwide. Every year close to 800,000 people die of suicide (World Health Organization, 2019). This phenomenon occurs in all age groups, but it is also the second leading cause of death after accidents for people aged ten to thirty- four (American Psychiatric Association, 2018). Suicide also accounts for 6% of deaths among young people, the second cause of death for females and the third cause of death for

males between ten to twenty-four years-old (McKinnon, Gariépy, Sentenac, & Elgar, 2016). These statistics are what make suicide a serious problem in public health worldwide.

Suicidal ideation often begins in adolescence and is prevalent among individuals in this particular age group, but especially in females. Suicidal ideation has a strong relationship to suicide attempts, behavior and suicide. It was estimated that in middle to low income countries there is a prevalence of 4.1% to 23.5% of suicide attempts in a lifetime (McKinnon, Gariépy, Sentenac, & Elgar, 2016).

Borderline Personality Disorder is one of the most difficult mental health disorders to treat and manage, meaning that often more than one type of professional treatment is needed. Worldwide, there are limited resources to treat mental health disorders which often results in them going untreated or individuals receiving poor quality treatment. Many individuals tend to look for help when they experience suicidal ideation, as happens with Borderline Personality Disorder but there is still a lack of treatment resources which needs to be available for these individuals. As personality disorders and suicide are highly prevalent, there needs to be a primary and efficient model of treatment provided for these individuals.

Research Question

To what extent could the implementation of Dialectical Behavioral Therapy (DBT) as the standard treatment for people with diagnosed Borderline Personality Disorder decrease the frequency and intensity of suicidal behavior, ideation and therefore completed suicide rates.

Study Purpose

This study proposes Dialectical Behavioral Therapy (DBT), which is a type of Cognitive Behavioral Therapy, originally developed for Borderline Personality Disorder, and that is now also used to treat self-harming, eating disorders, and substance abuse to reduce the frequency and intensity of suicidal ideation and behaviors in these individuals. The expected results should prove that this method of treatment will reduce the rates of suicidal behaviors,

suicidal ideation and completed suicide in individuals with Borderline Personality Disorder. This study has the purpose of improving the lives of those individuals who suffer from Borderline Personality Disorder, as well as reducing the mortality rates in this population.

Study Significance

The use of Dialectical Behavioral Therapy could improve quality of life for individuals diagnosed with Borderline Personality Disorder and generate a standard approach worldwide for treating suicidal behavior and ideation in these patients. Since suicide rates are rising, it is important for there to be a standard approach to preventing these behaviors that can ultimately lead to suicide. Dialectical Behavioral Therapy (DBT) may be the approach needed to target suicidal behavior and ideation and lead to the decrease of these and suicide rates worldwide.

LITERATURE REVIEW

Format of the Literature Review

The literature review includes seven topics: an explanation of personality disorders, an explanation of Borderline Personality Disorder, and the models used to explain it, the risk and protective factors that have been identified worldwide, treatment modalities, an explanation of Dialectical Behavioral Therapy (DBT), an explanation of suicide, suicidal ideation and suicidal behavior and their protective and risk factors.

1. Personality disorders

A personality disorder is when "a person's way of thinking, feeling, and behaving deviates from cultural expectation, causes distress or problems in their functioning which last over time" (American Psychiatric Association, 2018). It is estimated that around 10% of the general population suffers from some type of personality disorder (Dixon- Gordon, Whalen, Layden, & Chapman, 2015). It is also common for individuals with personality disorders to suffer from co-occurring mental disorders and physical conditions (Dixon- Gordon, Whalen,

Layden, & Chapman, 2015). Most individuals that are diagnosed with one personality disorder often also meet the criteria for another personality disorder (Bateman, Gunderson , & Mulder, 2015). Apart from this individuals are often diagnosed with another disorder such as: depression, anxiety, substance abuse, among others (Bateman, Gunderson , & Mulder, 2015).

Even though personality disorders, with the exception of antisocial personality disorder, cannot be diagnosed until the individual is 18 years old it is believed that personality disorders begin in childhood and adolescence. These different personality disorders often become apparent during the transition between childhood and adulthood, they also have the potential to interrupt this development and interfere with normal functioning (Newton-Howes, Clark, & Chanen, 2015). Personality disorders are thought to be caused by a combination of genetic traits as well as the individuals environment, and the way in which it influences them.

There are two main treatment approaches for personality disorders which are psychosocial and pharmacotherapy. However, psychosocial therapy is often used as the primary treatment method for all personality disorders, and is employed in a variety of different contexts, such as inpatient, partial hospital, and outpatient settings (Bateman, Gunderson , & Mulder, 2015). Psychosocial treatment aims to reduce acute life- threatening symptoms and to improve distressing mental state symptoms (Bateman, Gunderson , & Mulder, 2015). Pharmacological treatment only focuses on specific aspects of each personality disorder like the instability and cognitive disturbances an individual may experience (Bateman, Gunderson , & Mulder, 2015).

All ten personality disorders are divided into three different clusters according to their specific characteristics, based on their resemblance. The first cluster is cluster A, in which the odd or eccentric personality disorders are found (Barlow & Durand, 2015). There are 3 disorders in this cluster which are paranoid, schizoid, and schizotypal personalities. These

personality disorders are characterized by their inability to form close interpersonal relationships as well as their indifference to this disability, their social aversion and withdraw (Bateman, Gunderson , & Mulder, 2015). These individuals also have poor self-awareness as well as poor empathy and distorted thinking (Bateman, Gunderson , & Mulder, 2015). The psychosocial treatment that is most often employed in these personality disorders is cognitive therapy, as far as pharmacological treatment goes individuals are treated with typical and atypical antipsychotics which have shown to have some improvement (Bateman, Gunderson , & Mulder, 2015).

The second cluster of personality disorders is cluster B, which are described as "dramatic, emotional or erratic" (Barlow & Durand, 2015). There are four personality disorders in this cluster, they are "borderline, antisocial, histrionic, and narcissistic personalities" (Barlow & Durand, 2015). These personality disorders are characterized by individuals who are overly dramatic and have emotional thinking or behavior, they can also have problems with impulse control (Bateman, Gunderson , & Mulder, 2015). These individuals can be unpredictable in the way in which they interact with other people due to cognitive distortions which causes problems in their interpersonal relationships. There are a variety of psychosocial treatments that are employed in the treatment of cluster B personality disorders such as, talk therapy, cognitive behavioral therapy and Dialectical Behavioral Therapy (DBT) (Hooley & St. Germain, 2013). These types of therapy help individuals examine their thought patterns and behaviors as well as teach them skills to work on their interpersonal relationships and help them reduce their life threatening behaviors. These personality disorders can also be treated pharmacologically, because they often have co- occurring disorders such as depression or anxiety (Bateman, Gunderson , & Mulder, 2015). Most often these individuals are treated with antidepressants, antipsychotics and antianxiety medications.

The third and final cluster in which personality disorders are divided among is cluster C, which are described as “anxious and fearful” (Barlow & Durand, 2015). There are three personality disorders in this cluster which are: “avoidant, dependent, and obsessive-compulsive personalities” (Barlow & Durand, 2015). They are characterized as being marked by anxious thoughts and behaviors, individuals with these personality disorders often experience extreme fear that interferes with their daily lives. For these personality disorders psychosocial treatment is often used, the treatments that have most showed improved social functioning are psychodynamic therapy and cognitive behavioral therapy (Bateman, Gunderson , & Mulder, 2015). From a pharmacological form of treatment individuals are most often treated using antidepressants, anti-anxiety medication, mood stabilizers and antipsychotics (Bateman, Gunderson , & Mulder, 2015).

2. Borderline Personality Disorder, models used to explain it

Borderline personality disorder is defined by the Diagnostic and Statistical Manual, Fifth Edition (DSM- V) as a “dominant pattern of unstable interpersonal relationships, self-image, and affects as well as marked impulsivity that begins in early adulthood and is present in different contexts” (American Psychiatric Association, 2013). This personality disorder is characterized by profound emotional pain, that is perceived by the individual as the worst kind of pain anyone has ever felt (Hooley & St. Germain, 2013). It is also characterized by instability that can be reflected as inappropriate or intense anger as well as periods of rapidly changing emotions that are negative and that are in response to interpersonal stress (Hooley & St. Germain, 2013). Another hallmark of this personality disorder is that individuals often have a lot of trouble regarding their self-image, meaning that they have difficulty in maintaining a sense of who they are or what they want (Hooley & St. Germain, 2013). These individuals are also characterized by the fact that they are impulsive and have very unstable interpersonal relationships. A person that they love and idolize can turn into someone that

they hate in the same day. They are impulsive in many ways which often cause them damage and trouble. The impulsive behaviors that they usually engage in include reckless driving, risky sexual behavior, substance abuse, gambling or binge eating (Hooley & St. Germain, 2013).

Borderline Personality Disorder is highly comorbid with other disorders. These individuals are more likely to be diagnosed with other disorders than other individuals who do not have this personality disorder (Hooley & St. Germain, 2013). The disorders that are associated the most with Borderline Personality Disorder are "major depression, dysthymia, bipolar disorder, eating disorders, Post Traumatic Stress Disorder (PTSD), and substance abuse disorders" (Hooley & St. Germain, 2013).

Currently there are different theoretical perspectives and approaches that attempt to explain the etiology of Borderline Personality Disorder, but until now it is still unknown (Hooley & St. Germain, 2013). The first theoretical approach that is important to mention is the psychodynamic one. Within this approach one of the first theories regarding Borderline Personality Disorder was the one presented by Kernberg. In his theory, Kernberg stated that when an individual has a high level of constitutional aggression this can be a predisposing factor for the disorder (Hooley & St. Germain, 2013). When an individual has this according to Kernberg it interferes with normal developmental processes like the integration of different perspectives of the self and of others (Hooley & St. Germain, 2013). When this happens the individuals memories for example are stored either as good or bad, but not integrated as good and bad. Another theorist, Heinz Kohut also presented a theory that has been influential for Borderline Personality Disorder. What this theorist has proposed is the importance of the caretakers attunement to the needs of a child, which he refers to as "good enough mothering" (Hooley & St. Germain, 2013). He says is that when this happens the child is able to develop a good sense of self and has the ability to "regulate their own self esteem by drawing on an

internal representation of their caretaker as a source of emotional comfort or soothing" (Hooley & St. Germain, 2013). Drawing on this same theory Adler and Buie, theorized that individuals with Borderline Personality Disorder do not have the ability to draw on memories of what they call "good objects" to provide self- soothing in moments of distress, which is what causes their inability to regulate their own emotions (Hooley & St. Germain, 2013).

Another approach to understanding Borderline Personality Disorder is the behavioral one. Marsha Linehan's biosocial theory is an important contribution to understanding this. Her theory states that Borderline Personality Disorder results when "biological or temperamental vulnerabilities interact with failures in the individuals social environment to either create or exacerbate preexisting problems with emotion regulation" (Hooley & St. Germain, 2013). Another way to understand this is that "when an individual has high levels of sensitivity to negative emotions or has high emotional reactivity and a slow return to their baseline of emotions after being emotionally aroused these are considered precursors of problems with emotional regulation, which are characteristic of Borderline Personality Disorder" (Hooley & St. Germain, 2013). Linehan also states that if the family environment does not provide the individual with the tools necessary to regulate or contain these strong emotions than it is more likely that a diagnosis of Borderline Personality Disorder will result (Hooley & St. Germain, 2013). This model emphasizes that a key environmental factor is an invalidating family environment.

Another way in which Borderline Personality Disorder has been studied is genetics, although there is only some evidence that suggests that this disorder actually runs in families (Hooley & St. Germain, 2013). However the fact that it runs in families does not necessarily mean that it is genetic: it could be because of the individuals environment. What has been found in studies is that within families of individuals diagnosed with Borderline Personality Disorder there is evidence that shows that there are prevalence rates of mood, anxiety, and

impulse control disorders, which means is that what could be inherited are the traits that are linked to the dimensions of Borderline Personality Disorder not the disorder itself (Hooley & St. Germain, 2013).

Borderline Personality Disorder has also been studied in its psychosocial aspects. The two most important are childhood maltreatment and attachment. In many cases the early lives of those with Borderline Personality Disorder are characterized by high levels of trauma or adversity. These individuals were more likely to have suffered physical or sexual abuse as well as neglect during their childhood (Hooley & St. Germain, 2013). Other psychosocial aspects that have been seen is that their lives are characterized by maternal or paternal absence, discord between their parents as well as the fact that some individuals were raised by other family members or foster care (Hooley & St. Germain, 2013).

Attachment is also an important factor in Borderline Personality Disorder. In these individuals relationships tend to be extremely problematic, not only with others but also with themselves. These individuals tend to have concern with "abandonment, feelings of emptiness, lack of identity, self-harming behaviors and an inability to self sooth when they experience distress" (Hooley & St. Germain, 2013). Bowlby's attachment theory has also been used as an approach to conceptualize Borderline Personality Disorder. It proposed that through the relationships and transactions that individuals have with their caretakers they "develop mental representations about themselves and others which leads them to develop internal working models about what interpersonal relationships are" (Hooley & St. Germain, 2013). What this gives individuals is a set of expectations about relationships that then shape the nature of the relationships that they will develop in the future, as well as organize their personalities (Hooley & St. Germain, 2013). According to this theory "if an individual is raised by an abusive, neglectful, or emotionally disengaged caretaker, then their working

model of relationships can involve expectations of lack of care, unreliability, or unresponsiveness" (Hooley & St. Germain, 2013).

What is important to take into account from this is that each attachment style has some continuity from childhood into adulthood. According to Bowlby, childhood attachment influences the individual later in life in their capacity to make affectional bonds, as well as a whole range of adult dysfunctions such as difficulties with parenting and personality disorders (Hooley & St. Germain, 2013). In different studies it has been seen that most individuals with diagnosed Borderline Personality Disorder report an insecure attachment style, whereas only a minority reported a secure attachment pattern (Hooley & St. Germain, 2013). Attachment can therefore explain why individuals with Borderline Personality Disorder are extremely emotionally attached to safe and stable attachment objects throughout their lives (Hooley & St. Germain, 2013).

Finally according to Bateman and Fonagy the inability to mentalize is also associated to failures in early attachment, which is central to Borderline Personality Disorder. The ability to mentalize is defined as "being able to understand and interpret one's own mental states as well as those of others" (Hooley & St. Germain, 2013). This is because individuals with Borderline Personality Disorder experience real or misperceived interpersonal events can serve as triggers for "emotional outbursts, impulsivity or self- damaging behaviors" (Hooley & St. Germain, 2013).

3. Risk and protective factors for Borderline Personality Disorder

Borderline Personality Disorder is not usually the cause of one problem or circumstance but is something that develops with the influence of various different factors and situations. To begin with risk factors are those that can increase or enhance the probability that an individual has for developing something. There are different types of risk factors like social, familial, maltreatment, or trauma and child factors which can contribute to the development

of Borderline Personality Disorder. Some of the social risk factors that have been identified for Borderline Personality Disorder are for the individual to have a low socioeconomic status (Stepp, Lazarus, & Byrd, 2016). Another risk factor that was identified was having suffered stress early in life which also predicted a higher prevalence of Borderline Personality Disorder later in life (Stepp, Lazarus, & Byrd, 2016). Other social risk factors that were identified for Borderline Personality Disorder were family and school adversity and receiving public assistance (Stepp, Lazarus, & Byrd, 2016).

Other risk factors that can contribute to the development of Borderline Personality Disorder are family factors. One important family risk factor is the presence of maternal Borderline Personality Disorder (Stepp, Lazarus, & Byrd, 2016). Another family risk factor is the presence of maltreatment and maternal negative expressed emotion, as well as maternal and paternal substance abuse (Stepp, Lazarus, & Byrd, 2016). Maternal inconsistency or poor parenting can also influence an individual's later diagnosis of Borderline Personality Disorder and are therefore important risk factors (Stepp, Lazarus, & Byrd, 2016). Another risk factor is hostility, harsh parenting, or discipline (Stepp, Lazarus, & Byrd, 2016). Finally another familial risk factor that was identified was discord between mother and child or in other words the quality of the familial relationship (Stepp, Lazarus, & Byrd, 2016).

Maltreatment and other traumas can also be risk factors for Borderline Personality Disorder. Childhood abuse is one of the greatest risk factors for the development of later Borderline Personality Disorder. According to Stepp, Lazarus and Byrd, sexual, physical, verbal, and emotional abuse are considered to predict a later diagnosis of Borderline Personality Disorder, which makes them important risk factors (2016). Other trauma related risk factors are neglectful situations such as early maternal separation, inadequate supervision, and poor parental care (Stepp, Lazarus, & Byrd, 2016). Other risk factors identified are cumulative trauma, such as" parental incarceration, family suicide, or parental death are also

important for a later diagnosis of Borderline Personality Disorder" (Stepp, Lazarus, & Byrd, 2016).

Another type of risk factors that can contribute to Borderline Personality Disorders are child factors. First, cognitively low IQ rates were a risk factor identified (Stepp, Lazarus, & Byrd, 2016). Another was individuals that have insecure or disorganized attachment styles (Stepp, Lazarus, & Byrd, 2016). Temperament and personality risk factors that have been identified are negative affectivity such as emotionality, affective instability, and tantrums as well as impulsivity such as low self-control and low constraint (Stepp, Lazarus, & Byrd, 2016). Important risk factors that have been identified for Borderline Personality Disorder are also internalizing psychopathologies, such as anxiety, depression, dissociation, or suicidal ideation (Stepp, Lazarus, & Byrd, 2016). There are also risk factors associated with externalizing psychopathology such as "attention deficit hyperactivity, oppositional defiant disorder, conduct disorder, and substance abuse" (Stepp, Lazarus, & Byrd, 2016).

Protective factors are those that are associated with a reduced potential for the individual to develop Borderline Personality Disorder. According to the information provided above, protective factors against the development of Borderline Personality Disorder would be as follows. One protective factor would be for the individual to have a secure attachment style with their caretaker since infancy. Another one would be the absence of all types of abuse, such as sexual, physical, emotional, and verbal. For an individual to have a middle or higher class socioeconomic status is also a protective factor. The absence of familial psychopathology as well as good parenting are also important. Finally, the absence of life stressors and trauma are also protective factors against Borderline Personality Disorder.

4. Treatment modalities for Borderline Personality Disorder

There are a variety of different types of treatments currently available for Borderline Personality Disorder. Because of this the long term outcome for individuals diagnosed with

the disorder is considered to be more benign than what was previously thought (Hooley & St. Germain, 2013). There are two different approaches to treatment in this disorder: pharmacological and psychological. Pharmacological treatment is often used routinely in treatment, but more so as a complement to psychological treatment.

There are different medications that are used in pharmacological treatment, the most common of these are antidepressants. Other types of medications that are used are atypical antipsychotics and mood stabilizers. In terms of antidepressants, the ones that are most commonly used are Selective Serotonin Reuptake Inhibitors (SSRI's). These are used because many individuals diagnosed with Borderline Personality Disorder are also depressed (Hooley & St. Germain, 2013). Another reason that this specific medication has been proven to be effective for the treatment of Borderline Personality Disorder is because it is also characterized by aggression and suicidal behavior which has been linked to low levels of serotonin (Hooley & St. Germain, 2013). These types of antidepressants have also shown to be helpful in decreasing the mood shifts that these individuals are prone to experience.

Another type of medication that is used in the pharmacological treatment of Borderline Personality Disorder are atypical antipsychotics. These medications are beneficial to these individuals because they have an effect on the impulsivity and aggression that they often experience (Hooley & St. Germain, 2013). Finally, mood stabilizers are also used because they are often useful in that they help with anger and the mood instability that individuals are prone to experience (Hooley & St. Germain, 2013). Something that is important to take into account however is that pharmacological treatment is individual specific for Borderline Personality Disorder and that this type of treatment can help individuals with some of their symptoms but not all of them, which means that they must also attend psychotherapy as part of an effective treatment plan.

The other approach to treating Borderline Personality Disorder is through psychotherapy. There are a variety of different therapies that can be effective for an individual with this disorder. The types of therapy that are used for Borderline Personality Disorder are "Dialectical Behavioral Therapy (DBT), schema-focused therapy, mentalization-based therapy, systems training for emotional predictability, and problem solving and transference-focused psychotherapy" (American Psychiatric Association, 2018). Schema-focused therapy is a type of therapy that is founded on the principals of cognitive behavioral therapy. The aim of this type of therapy is to help individuals change their schemas or ways of thinking "by using cognitive, behavioral, and emotion focused techniques" (American Psychological Association, 2016). What this type of therapy focuses on is "the relationship with the therapist, daily life, traumatic childhood experiences, all things that are common with Borderline Personality Disorder patients" (American Psychological Association, 2016).

Transference-focused psychotherapy, which focuses on the causes that underlie the disorder and then works on building a new and healthy way for the individual to think and behave (American Psychological Association, 2016). What this type of therapy assumes is that since the individuals perceptions of themselves and others are located in unrealistic extremes of good and bad, this conflict expresses itself through the self-destructive borderline symptoms (American Psychological Association, 2016). In this therapy, what is expected to happen is for the individual to transfer their feelings and ways of thinking onto the therapist so they can then help them to integrate these two different representations of good and bad in themselves and others to develop better methods of self-control (American Psychological Association, 2016).It has been demonstrated that schema-focused therapy is more effective then transference-focused psychotherapy in the treatment of Borderline Personality Disorder (Glesen- Bloo & et al, 2006).

Another type of therapy that is used in Borderline Personality Disorder is mentalization-based therapy. In one of the models that was previously discussed Bateman and Fogany stated that individuals with Borderline Personality Disorder have an inability to mentalize which is a central aspect of the disorder. Therefore mentalizing is defined as "the process by which individuals make sense of each other and themselves in terms of subjective states and mental processes" (American Psychological Association , 2016). This type of treatment however is time limited and structures interventions that "focus and promote the development of mentalizing" (American Psychological Association , 2016).

Systems training for emotional predictability and problem solving is another type of psychological treatment that is used in Borderline Personality Disorder. This treatment is a 20 week structured program that combines cognitive behavioral therapy and skills training, as well as a systems component for individuals with which the patient interacts with on a regular basis (Blum, et al., 2008). This treatment has three different components: "psychoeducation about Borderline Personality Disorder, emotion management skills training, and behavior management skills training" (Blum, et al., 2008). The first component focuses on teaching the individuals to replace misconceptions about the Borderline Personality Disorder, the second component teaches them skills to the manage cognitive and emotional effects of the disorder in a better ways, and the third component teaches them behavioral skills such as "goal setting, eating behaviors, sleep hygiene, regular exercise, leisure activities, medication adherence, avoiding self-harm and interpersonal effectiveness" (Blum, et al., 2008). The last type of treatment that is used is Dialectical Behavioral Therapy (DBT) and will be discussed in depth next.

5. Dialectical Behavioral Therapy (DBT)

Dialectical Behavioral Therapy (DBT) is the best known treatment for Borderline Personality Disorder. It was developed by Marsha Linehan specifically for individuals with

Borderline Personality Disorder. This is a type of psychotherapy that has a cognitive behavioral approach and also emphasizes the psychosocial aspects of treatment for these individuals. The approach that is behind this type of therapy is that "some individuals are more prone then others to react in more intense or out of the ordinary ways in certain situations, especially those involving family, friends, and romantic relationships" (Grohol, 2019). What the theory in Dialectical Behavioral Therapy (DBT) suggests is that some people's arousal levels can increase more quickly than the average person and that they can also achieve a higher level of emotional stimulation, as well as take more time to return to a baseline level of arousal (Grohol, 2019).

Dialectical Behavioral Therapy (DBT) is divided into different components. First it is support oriented, meaning that one of the goals that is has is to "help the individual to identify their strengths and build on them so that they can feel better about themselves and their lives" (Grohol, 2019). The next component is that it is cognitive based, which means that "it helps individuals to identify thoughts, beliefs and assumptions that they have that can make their lives more challenging" (Grohol, 2019). The next component is that it is collaborative, meaning "it requires constant attention regarding the relationships between the therapist and the patient and it also aims for patients to be able to work out their problems in their relationships with their therapists and for the therapists to do the same with them" (Grohol, 2019). This type of therapy requires individuals to complete homework assignments, role-play interactions with others and to practice different skills such as self-soothing (Grohol, 2019). Dialectical Behavioral Therapy (DBT) is characterized by weekly individual and group psychotherapy sessions.

Dialectical Behavioral Therapy (DBT) is divided into four different modules, "mindfulness, interpersonal effectiveness, distress tolerance, and emotion regulation" (Grohol, 2019). The first module is mindfulness, in which individuals are taught to pay

attention to the present in a way that is not judgmental. People are taught to live in the moment, and to experience their emotions and senses with perspective, which relies on acceptance from the individual (Grohol, 2019). This module also consists of mindfulness skills taught through how and what skills. What skills consists in answering the question of what individuals should do to practice core mindfulness skills, and how skills answers the question of how the individuals practice those mindfulness skills (Grohol, 2019).

The second module in Dialectical Behavioral Therapy (DBT) is interpersonal effectiveness. Individuals with this personality disorder often experience problems with their interpersonal relationships even though they tend to have good interpersonal skills. This module aims to teach skills such as "strategies for asking for what the individual needs, how to assertively say "no", as well as learning to cope with inevitable interpersonal conflict" (Grohol, 2019). The interpersonal response patterns that are taught in this module are similar to those that are sometimes taught in "assertiveness and interpersonal problem-solving classes" (Grohol, 2019). It also focuses on situations in which the objective is to change something or to resist it, the goal is to maximize the chance that the individuals goals will be met in a certain situation, without damaging the relationship or the persons view of themselves (Grohol, 2019).

The third module is distress tolerance. Dialectical Behavioral Therapy (DBT) makes an important emphasis on the fact that it is important to learn to bear pain in a skillful manner. These skills are derived from mindfulness, the first module taught in this therapy. These skills have a lot to do with the ability to be able to accept in a non-judgmental or evaluative way the current situations that the individual is experiencing (Grohol, 2019). What these behaviors are mainly concerned with are the individual being able to tolerate and survive their crisis and accepting them in that moment. In this module, four different distress tolerance strategies are taught: "distracting, self-soothing, improving the moment and thinking of pros and cons"

(Bray, 2013). Distracting aims to help the individual shift their focus from thoughts or emotions that are upsetting to more enjoyable or neutral ones (Bray, 2013). Self-soothing teaches the individuals to use their five senses in times of distress to nurture themselves (Bray, 2013). The way this is done is first of all through vision, by having the individual look at beautiful things, then through hearing, things like music or nature, also through smells such as scented candles or perfume, and through taste, by indulging in a meal or desert. Finally, by touching a pet or hugging someone or a soft blanket (Bray, 2013). The last skill taught is focusing on pros and cons, what this consists of is making a list of the pros and cons of tolerating distress or not tolerating it, individuals are also asked to imagine how it would feel to be able to successfully tolerate distress and avoid those negative behaviors they would usually use to cope. This aims to reduce the impulsive reactions that individuals may have (Bray, 2013).

The fourth and final module of Dialectical Behavioral Therapy (DBT) is emotion regulation. Because individuals with Borderline Personality Disorder are often emotionally intense, meaning they frequently experience anger, frustration, depression, and anxiety, it is important for them to learn how to regulate their emotions. This is done through a variety of different skills. These skills are, “learning to properly label and identify their emotions, being able to identify obstacles that are in the way of them changing their emotions, increasing positive emotional events, increasing mindfulness to current emotions, learning to take opposite action, and finally applying distress tolerance techniques taught in the previous module” (Bray, 2013).

6. Suicide, suicidal ideation and suicidal behavior

Suicide can be defined as the act of killing oneself. According to the theory of Emile Durkheim, a French philosopher, there are four different types of suicide: “egotistic, altruistic, anomic and fatalistic” (Moore, 2016). Egotistic suicide, according to Durkheim, occurs when

"an individual becomes socially isolated or feels that they no longer have a place in society and therefore choses to kill themselves" (Moore, 2016). Altruistic suicide occurs when "individuals and a group are too close or intimate" (Moore, 2016). It is the result of an individual proving themselves to the group (Moore, 2016). Anomic suicide, according, to Durkheim "is due to a breakdown of social balance" (Moore, 2016). Finally, fatalistic suicide is due to "the overregulation in society" (Moore, 2016). According to the American Psychiatric Association, suicide in the United States is the cause of death in about 2% of the cases in people aged 15 to 24 (2018), and according to the World Health Organization around 800,000 people die by suicide every year (2019).

Suicidal ideation is when an individual has thoughts about committing suicide. There are two different types of suicidal ideation: passive and active. Active suicidal ideation is "when the individual has thought about suicide, has a plan, a method, and actually intends to commit suicide" (Purse, 2019). Passive suicidal ideation is "when an individual wishes that they would die, but they do not actually make any plans to commit suicide" (Purse, 2019). In one year there was approximately a prevalence rate of 2% worldwide for suicidal ideation and a 9% lifetime prevalence for it (Schreiber & Culpepper, 2019). It was also found that individuals who have a history of suicidal ideation have an increased 33% chance of having a suicide plan and a 55% chance of actually attempting their plan (Schreiber & Culpepper, 2019).

Suicidal behaviors are those actions in which individuals cause intentional bodily harm to themselves that could possibly lead to death. There are different types of behaviors that are seen as suicidal, the most common being cutting and burning. Most frequently individuals resort to cutting themselves, and in some cases they also burn themselves. Suicidal behaviors are present not only in Borderline Personality Disorder but in a wide variety of mental disorders such as depression, eating disorders and substance abuse. These behaviors are also

referred to as “deliberate self- harm, a type of self- injurious behavior that includes suicide attempts and non-suicidal self- injurious behaviors, in which individuals do not have the intent to die” (Turecki & Brent, 2016).

7. Risk and protective factors of suicide, suicidal ideation and suicidal behaviors.

Suicide is not usually the result of one isolated problem. Most often suicide is the result of persistent mental health problems. As with all mental health disorders there are protective factors against suicide as well as risk factors. Risk factors are those which could increase the probability that an individual could commit suicide. Protective factors on the other hand are defined as those which decrease the probability that an individual will commit suicide

Risk factors can be divided into different types, in this case there are risk factors reflected in “talk, behavior, mood, health, environmental factors, and historical factors” (American Foundation for Suicide Prevention, 2019). Risk factors associated to talk are when individuals “talk about killing themselves, about being hopeless and having no reason to live, feeling like a burden to others or, feeling trapped” (American Foundation for Suicide Prevention, 2019). Those associated with behavior are when an individual has an increased use of alcohol or drugs, when they have researched ways to end their lives, when they withdraw from activities, and isolate themselves from friends and family (American Foundation for Suicide Prevention, 2019). When their sleep patterns increase or decrease, when the individual also becomes aggressive or feels more fatigued than usual (American Foundation for Suicide Prevention, 2019). The risk factors that mood refers to are when an individual is depressed, anxious, irritable or loses interest as well as experiences agitation or anger (American Foundation for Suicide Prevention, 2019). One of the most important risk factors related to mood is when an individual experiences relief or sudden improvement (American Foundation for Suicide Prevention, 2019).

Risk factors concerning health are associated with mental health conditions such as "depression, substance abuse, bipolar disorder, schizophrenia, personality traits such as aggression, mood shifts or poor relationships, as well as conduct or anxiety disorders" (American Foundation for Suicide Prevention, 2019). Other risk factors regarding health are for an individual to have serious physical conditions or a traumatic brain injury (American Foundation for Suicide Prevention, 2019). Environmental risk factors are those such as "the individual having access to lethal means such as drugs or firearms, or being under prolonged stress such as harassment, bullying, stressful life events such as rejection, divorce or a financial crisis and finally being exposed to another individuals suicide" (American Foundation for Suicide Prevention, 2019). Finally, historical risk factors for suicide are "having a previous suicide attempt, a family history of suicide and childhood abuse, neglect or trauma" (American Foundation for Suicide Prevention, 2019). Risk factors identified for suicidal ideation and behavior are being female, being younger, as well as less educated and having a mental disorder (Nock, Borges , Bromet, & Alonso, 2008). Other risk factors identified for suicidal behavior were low socioeconomic status and the experience of childhood abuse (Kliem, Lohmann, Möble, & Brähler, 2017).

Protective factors for suicide can be summarized into five major factors. First, it is important for the individual to have access to effective behavioral health care (Suicide Prevention Resource Center , 2019). Another protective factor is for the individual to be connected to other individuals such family, friends, community, or social institutions (Suicide Prevention Resource Center , 2019). One of the most important protective factors is "for the individuals to have life skills such as problem solving and coping skills and the ability to adapt to change" (Suicide Prevention Resource Center , 2019). It is also important for the individual "to have self- esteem and a sense of purpose or meaning in their lives" (Suicide Prevention Resource Center , 2019). The last major protective factors for suicide are "the

individuals cultural, religious or personal beliefs" (Suicide Prevention Resource Center , 2019).

METHODOLOGY AND RESEARCH DESIGN

This research study is based on the question: To what extent could the implementation of Dialectical Behavioral Therapy (DBT) as the standard treatment for people with diagnosed Borderline Personality Disorder decrease suicidal behavior, ideation and completed suicide rates? This methodology will consist of a quantitative design using a statistical ANOVA for repeated measures to analyze results.

Methodology and Design Justification

The aim of this study is to evaluate the possibility of reducing suicidal ideation, suicidal behavior, and completed suicide rates through the application of Dialectical Behavioral Therapy (DBT) in Borderline Personality Disorder patients. A quantitative design will be used for this study because, according to Mujis, it explains the phenomena through the collection of the numerical data that are analyzed by using methods that are based on mathematics (Mujis, 2004). The Columbia-Suicide Severity Rating Scale was designed to quantify the severity of suicidal behavior and suicidal ideation (Lotito & Cook, 2015). This scale examines an individual's life to then pinpoint when the worst-point ideation occurred, because research has suggested that worst-point ideation is a stronger predictor of suicide attempts rather than any current ideation the individual may have, as well as the intent and lethality of previous attempts (Lotito & Cook, 2015). The assessment of this scale is divided into four constructs: the severity of the suicidal ideation, the intensity of the suicidal ideation, suicide behavior, and lethality. This scale also has a focus on preparation behaviors for suicide acts which have been associated with later suicide attempts (Lotito & Cook, 2015). This specific scale is also useful for detecting changes in suicidal thinking and behavior over time (Lotito & Cook, 2015).

The participants in this study will receive three questionnaires in a time frame of twelve months. The first questionnaire will be applied before the beginning of the Dialectical Behavior Therapy (DBT), the second will be applied six months after the beginning of treatment, and the last one will be applied twelve months after the individual has started therapy. The questionnaires will be applied in this way because it will be useful for the experiment to analyze the results of each individual at different time points in the study. In this study the dependent variable is the application of Dialectical Behavioral Therapy (DBT) and the independent variables are the diagnosis of Borderline Personality Disorder, suicidal ideation, suicidal behaviors, age and sex. For this study a quantitative design using ANOVA for repeated measures will be used, because it measures and points out any differences between mean scores, as well as the fact that it is also useful to note changes in the mean scores over three or more points in time (Lund Research, 2018). The ANOVA for repeated measures will determine any statistical significance in the study, therefore it will analyze whether Dialectical Behavioral Therapy (DBT) had a significant effect in reducing suicidal ideation, suicidal behavior and completed suicide rates, thus evaluating the validity of the hypothesis.

Participants

The participants for this study will be recruited from a variety of different places. The way in which this will be done is through different types of advertisement, such as brochures placed in universities, clinics and hospitals. Another method to recruit participants will be through the use of different media platforms in which advertisements will also be placed, in order for the selection of participants to be random. The individuals will then be assessed with the Diagnostic and Statistical Manual, Fifth edition (DSM- V) and the Columbia-Suicide Severity Rating Scale in order to evaluate if they have Borderline Personality Disorder as well as suicidal ideation and behaviors.

Inclusion criteria include:

1. Participants with Borderline Personality Disorder
2. Participants older than 18 years of age
3. Participants with at least eight years of formal education
4. Participants that have agreed to the informed consent

Exclusion criteria include:

1. Participants with cognitive impairments
2. Participants who are attending other types of treatment

Research Tools

For this study the Columbia-Suicide Severity Rating Scale will be used. This assessment is useful to identify suicidal ideation, suicidal behavior and lethality in individuals, as well as preparation behaviors for suicidal acts. Participants will need approximately ten minutes to complete this questionnaire. This screening tool for suicidal ideation and behavior has strong validity, reliability, and is also sensitive to change over time, therefore the results obtained are statistically significant (Posner , et al., 2011). This particular tool is also useful because it distinguishes between the domains of suicidal ideation from suicidal behavior, and significantly improves the identification of high-risk patients (Posner , et al., 2011).

The Columbia-Suicide Severity Rating Scale consists of four different constructs that measure there subsequent subscale. The first one is severity of ideation, "which is rated on a 5- point ordinal scale were 1 equals wishes to be dead, 2 equals nonspecific active suicidal thoughts, 3 equals suicidal thoughts with methods, 4 equals suicidal intent and 5 equals suicidal intent with plan" (Posner , et al., 2011). The second component is the intensity of ideation, "which is made up of 5 items which are frequency, duration, controllability, deterrents and reason for ideation and each of the items is rated on a 5-point scale" (Posner ,

et al., 2011). The third component, suicide behavior, "which is also rated on a nominal scale includes items on actual, aborted and interrupted suicidal behaviors, as well as preparatory behaviors and no suicidal self- injurious behaviors" (Posner , et al., 2011). The final component of this assessment tool is lethality, "this component assess actual attempts and actual lethality on a 6- point ordinal scale, but if lethality is zero, then potential lethality of attempts is rated on a 3- point ordinal scale" (Posner , et al., 2011).

It is also important to note that this tool uses different assessment periods, which depend on the research study or the clinical need (Posner , et al., 2011). Apart from this the lifetime period which assesses the worst- point ideation makes this an effective tool, because according to research this is a strong predictor of suicide rather than any current suicidal ideation (Posner , et al., 2011). What also makes this tool effective is that in the component assessing suicidal behavior not only asks about actual attempts, but also attempts that were interrupted, being that they are also predictors of suicide, as are preparatory behaviors (Posner , et al., 2011).

The Columbia-Suicide Severity Rating Scale was designed for four different purposes. The first was to provide a definition of suicidal ideation, suicidal behavior and no suicidal self-injurious behavior (Posner , et al., 2011). The second purpose was to be able to quantify the spectrum of suicidal behavior and ideation to be able to see their severity over specific periods of time (Posner , et al., 2011). The third one was to be able to distinguish suicidal and non-suicidal self-injurious behaviors (Posner , et al., 2011). The last purpose that this scale had was to make sure it was user friendly which would allow for the integration of information from more than one source, such as the patient, the family and medical records (Posner , et al., 2011).

In this study there will be availability for 100 participants. Individuals will be informed about the research study and the purpose that is has, afterwards they will be given

an informed consent which will previously be approved by the ethics committee of Universidad San Francisco de Quito (USFQ). According to Dialectical Behavioral Therapy (DBT) guidelines participants will be required to meet weekly for individual and group sessions. The application of Dialectical Behavioral Therapy (DBT) is expected to provide individuals with a long-term outcome in the management of suicidal ideation and suicidal behavior in Borderline Personality Disorder patients, and therefore reduce these rates.

Data Collection

The recruitment for participants, as has been mentioned, will be through different places such as hospitals, clinics and universities through advertisement. After participants are randomly selected they will be interviewed to determine whether they fit the inclusionary criteria established for this study. When participants are determined to fit the inclusionary criteria they will be given an informed consent. Because this study will examine the effectiveness of Dialectical Behavioral Therapy (DBT) in the reduction of suicidal ideation, suicidal behavior and completed suicide rates in Borderline Personality Disorder sessions will follow these guidelines, meaning participants must participate both in individual and group sessions. What this means is that participants will go to group therapy once a week for an hour as well as going to individual therapy once a week for an hour.

Data Analysis

The data collected will be analyzed by using ANOVA for repeated measures, being that the design of this study is quantitative, and that data will be collected over three different points in time.

The first Columbia-Suicide Severity Rating Scale will be administered to individuals before the beginning of the study. After this results will then be documented so that then they can be analyzed using ANOVA repeated measures. The second questionnaire will be administered at the six month mark of the study and subsequently results will be documented

alongside those first obtained. Lastly, the questionnaire will be administered at the end of the study at the twelve month mark and documented with the previous results so that than an ANOVA repeated measures test may take place to determine if the results of the intervention were significant.

Ethical Considerations

Because of the stigma attached to mental health disorders and possible discrimination that participants could face, this study will maintain complete anonymity. Each participant that is a part of the study will be assigned a code to identify them for the duration of the investigation. Because part of the study consists of group therapy, participants will also be assigned an alias to use during these sessions. Each document and questionnaire that contains participant information will be stored in secure files. Documents used during the process will only contain the participants code or alias for identification. Confidentiality will be maintained throughout the study. The only instance in which confidentiality will be broken is if participants meet the requirements at the therapist discretion to make them believe that their life is at risk. If participants misses three consecutive individual or group sessions they may no longer participant in the study. Participants are also free to leave the study at any time. Finally participants are also at liberty to ask for their results at the end of the study or at any given time during it.

PROBABLE RESULTS

At the beginning of the study it is expected that individuals are actively participating in Dialectical Behavioral Therapy (DBT) and therefore it would be expected that the intensity and frequency of symptoms regarding suicidal ideation and behavior will decrease. According to Chapman for Dialectical Behavioral Therapy (DBT) to be effective, the emphasis is on the essential parts of the treatment that are unique to it, such as “the five functions of treatment,

the biosocial theory, focusing on emotions in treatment, the dialectical philosophy and finally acceptance and mindfulness" (2006).

The five functions of treatment are "the ability to enhance capabilities, to then generalize those capabilities, improve motivation and reduce dysfunctional behaviors, enhance, and maintain therapist capabilities and motivation and finally structure the environment"(Chapman, 2006). The first function refers to the assumption that is made that individuals with Borderline Personality Disorder either lack or need to improve on different life skills, like emotion regulation or tolerance distress (Chapman, 2006). The second function, "generalizing capabilities", refers to being able to generalize those skills learned so that individuals can apply them in their everyday lives (Chapman, 2006). The third function involves improving the individuals motivation towards change and too change behaviors that are inconsistent (Chapman, 2006). The forth functions primary goal is to maintain the motivation and skills that the individual has gained (Chapman, 2006). Finally, the last function, structuring the environment involves "structuring the environment in a way that reinforces the effective behavior and progress in a way that does not reinforce maladaptive or problematic behavior" (Chapman, 2006).

What the biosocial theory proposes is that "individuals with Borderline Personality Disorder are born with a biological temperament or disposition towards emotion vulnerability, meaning that they have a low threshold for responding to emotional stimuli or intense emotions" (Chapman, 2006). Therefore Dialectical Behavioral Therapy (DBT) is an emotion focused treatment, which has the goal to improve the patients quality of life by reducing ineffective ways of responding to these emotions (Chapman, 2006). Another key element for the effectiveness of Dialectical Behavioral Therapy (DBT) is the dialectical philosophy the treatment has. What this philosophy proposes is that polar forces create tension, so this

therapy must take into account not only change oriented efforts but must also focus on acceptance to create a balance (Chapman, 2006).

The last essential element for Dialectical Behavioral Therapy (DBT) to be effective is acceptance and mindfulness. Mindfulness is a key part of this therapy because it teaches individuals to accept themselves and to attend to what is happening in the present (Chapman, 2006). The acceptance component of this is in teaching the individual to accept the experience in the moment without changing it or resisting it (Chapman, 2006).

Dialectical Behavioral Therapy (DBT) usually lasts up to one year, because individuals take time to go through the four modules of treatment. It is likely that in the first three months of treatment participants will have completed the first module, mindfulness. It can be predicted that in most individuals suicidal ideation and behaviors will not yet be drastically reduced during this initial phase of treatment.

By the sixth month of treatment it can be predicted that participants will have finished the second module of treatment which is interpersonal effectiveness. By this time in point it would be expected that individuals have acquired and maintained the skills taught in therapy and that the frequency and intensity of suicidal ideation and behaviors have somewhat declined. Participants should also see improvement in their interpersonal relationships and in the ways in which they cope with conflict. By this point in time it can also be expected that some participants have abandoned the study.

By the ninth month of treatment it is expected that participants have finished the third module of Dialectical Behavioral Therapy (DBT), distress tolerance. Individuals should have been able to maintain all skills that they have acquired so far as well as the ones taught in this last module. Participants should be able to tolerate and survive crisis more effectively. They should also be implementing the skills taught for distress tolerance, such as self- soothing and

distracting. It can also be predicted that suicidal ideation and behaviors will have declined more markedly.

By the twelfth month of treatment all remaining participants are expected to have finished the forth module, emotion regulation. Participants should be able to regulate their emotions more effectively and therefore mood shifts should be experienced less often. Since by this point in time individuals should be finished with Dialectical Behavioral Therapy (DBT) suicidal ideation and behaviors should have decreased dramatically in intensity and frequency.

DISCUSSION

As a conclusion of the investigation, the research question: *To what extent could the implementation of Dialectical Behavioral Therapy (DBT) as the standard treatment for people with diagnosed Borderline Personality Disorder be effective in decreasing suicidal behavior, ideation and completed suicide rates?* will be discussed.

The purpose of this study was to examine the effectiveness that Dialectical Behavioral Therapy (DBT) has on reducing rates of suicidal ideation, suicidal behaviors and completed suicide in individuals diagnosed with Borderline Personality Disorder. The Columbia-Suicide Severity Rating Scale, the research tool used for this investigation, is very effective because it not only takes into account suicidal ideation and behaviors but also lethality and gives researchers a better understanding of the intensity and frequency that individuals experience them. By taking this into account, those individuals suffering from Borderline Personality Disorder will be the ones who are most benefited by this treatment. However because of the effectiveness of this type of treatment for suicidal ideation and behaviors, it would also be important to take this research into account with different populations, such as those individuals only diagnosed with depression who are also at risk for suicide.

The aim that this study has is to be able to develop a clear understanding of how Dialectical Behavioral Therapy (DBT) works in the reduction of suicidal ideation and behaviors. This research also has the aim that through the implementation of this specific treatment the quality of life of these individuals will improve as well as their life expectancy.

Dialectical Behavioral Therapy (DBT) has the potential to help reduce suicidal ideation and behaviors because of the different range of skills that individuals are taught during therapy. Because characteristics of this personality disorder are problems in interpersonal relationships as well as fear of abandonment the modules in distress tolerance and emotion regulation are of great importance so that individuals can handle their emotions which are often what leads them to suicidal behaviors in times of crisis.

It is also important to take into account that individuals with diagnosed Borderline Personality Disorder as well as other comorbid disorders such as substance abuse, eating disorders, and depression may also benefit greatly from this intervention.

The implementation of this intervention should also be carefully monitored and implemented by a trained therapist in Dialectical Behavioral Therapy (DBT) in the individual sessions and group sessions. This is of extreme importance, because an experienced therapist will be a determinant of the effectiveness of the treatment.

Finally it is also important to consider that Dialectical Behavioral Therapy (DBT) is one of few treatments that has proved to be effective for Borderline Personality Disorder, and therefore has the potential to help with more than one symptom of the disorder. Because of the focus each of the modules has the individual could improve on skills they previously had as well as gain new ones, which have the potential to help them in their everyday lives. This could also help decrease suicidal ideation and behaviors, as well as increase life expectancy for these individuals.

LIMITATIONS

In this study there are some limitations that could potentially impact the validity of the results obtained in this research study. To begin with, even though women are more frequently diagnosed with Borderline Personality Disorder, men are also diagnosed so it is important for there to be a distinction between the gender of the participants. Individuals may also vary in age, so there must also be a distinction regarding this when analyzing the data obtained.

It is also important to take into account that there may be different research tools, other than the Columbia-Suicide Severity Rating Scale that may also be more effective in assessing suicidal ideation and behaviors in this population, because there is no evidence that this questionnaire has been used for individuals with Borderline Personality Disorder. The results obtained may also not be generalized due to the small sample that was used in this investigation. The final limitation that must be taken into account is regarding the methodology of the investigation, in that it did not take into account screening to assess different factors such as participant socio-economic level, demographics, religious beliefs, or previous treatment they might have had which may influence the results and effectiveness of the therapy used for this investigation.

FUTURE RECOMMENDATIONS

For future research, it is recommended that a bigger sample be used so that results may be generalized. Participant socioeconomic status, religious beliefs, prior treatment, and demographic characteristics must also be taken into account prior to the beginning of research. Better outcomes could also be predicted if participants with comorbid disorders are those such as substance abuse or eating disorders, in which Dialectical Behavioral Therapy (DBT) has already proven effective. Participants should also be retested twelve months after the end of treatment to evaluate if results have been maintained over time.

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Appendixes

Appendix 1

Mindfulness Skills

Spending a lot of time in your head causes stress. There are always new things to worry about, conversations to rehearse, and activities to plan. Research tells us that when you live in the moment--that is, getting out of your head and being consciously aware of your surroundings--you will usually feel happier and experience less stress. With enough practice, you will learn to better control your thoughts and feelings. Below are some techniques to help you achieve this goal.

Mindful Activity

The goal of a *mindful activity* is to bring your thoughts into the present moment. To practice, first choose any activity where you notice your mind consistently wanders. This could be your commute home, while completing chores around the house, or just about anything else. Next time you do your chosen activity, attend to each of your senses. Below we use the example of going for a walk. It will be best to choose an activity you do regularly so you are sure to practice every day.

Vision	As you leave your home you immediately notice the bright blue sky, trees, and empty streets. As you pay closer attention you notice flowers along the sidewalk with a slight breeze causing them to tilt to their side every few moments.
Hearing	Each time the breeze passes, you can hear the leaves rustling in the wind. Occasionally, you hear the hum of a car passing on a nearby street. Birds are chirping somewhere up above.
Touch	You notice the warmth of the sun and the coolness of the breeze. With each step you feel your foot landing and then pushing off from the pavement.
Taste	You stop to pick up a coffee for your walk. You hold the drink in your mouth for a moment to savor the taste.
Smell	When the breeze floats by, you catch the smell of the flowers and the trees. As you continue your walk, you notice the smell of freshly cut grass by a neighboring home.

Appendix 2

Mindfulness Skills

Mindful Meditation

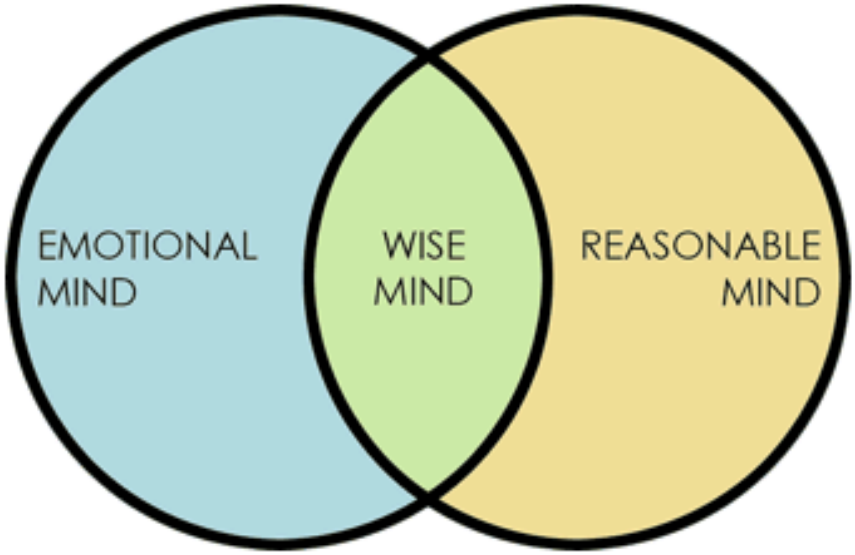
When you go about your life, it's normal for thoughts, feelings, and experiences to come and go quickly, oftentimes outside of your awareness. You might say or do something because of how you feel, without noticing the processes that influenced you. During mindfulness meditation you will create awareness of these processes by mentally taking a step back from yourself and identifying your thoughts, feelings, and physical sensations.

1	Find a place free of too much noise or distraction to practice.
2	Sit down on a cushion, the floor, or in a chair. You want to sit up straight to allow easy breathing, but not so straight that you're uncomfortable.
3	Turn your focus toward your breathing. Notice the feeling of the breath entering your body and making its way to your lungs. Pay attention to how your body feels, and what it's like as your breath exits your lungs. Continue to focus on the feeling of breathing.
4	As you practice, your mind will wander. Try not to judge your thoughts--simply accept that they are happening. Notice, as an outside observer: "I'm having a thought." The same goes for feelings. If you detect sadness, worry, happiness, or excitement, notice how they feel in your body. Acknowledge what you are feeling, even if it's an uncomfortable sensation. Simply notice: "I am feeling this way."
5	When the thought or feeling passes, return your focus to your breathing and your body.
6	Try to practice for at least 10 to 15 minutes. If you are more experienced, aim for 30 minutes.

Appendix 3

The Wise Mind

Your mind has three states: The reasonable mind, the emotional mind, and the wise mind. Everyone possesses each of these states, but most people gravitate toward a specific one most of the time.



A person uses their **reasonable mind** when they approach a situation intellectually. They plan and make decisions based off of fact.

The **wise mind** refers to a balance between the reasonable and emotional halves. They are able to recognize and respect their feelings, while responding to them in a rational manner.

The **emotional mind** is used when feelings control a person's thoughts and behavior. They might act impulsively with little regard for consequences.

Describe an experience you've had with each of the three states of mind.

Reasonable	
Emotional	
Wise	

Appendix 4

Interpersonal Effectiveness Skills

Learning to get along with others while also asserting your own needs is essential to healthy relationships. It can be difficult to balance your own needs and the needs of others. How can you get what you need without being aggressive or neglecting of the needs of others? There are three sets of skills you will learn to help achieve this goal: objective effectiveness, relationship effectiveness, and self-respect effectiveness.

Objective Effectiveness (D.E.A.R. M.A.N.)

What is the goal of an interaction? *Objective effectiveness* is about getting what you want out of a situation. The acronym D.E.A.R. M.A.N. will remind you how to clearly express your needs or desires.

Describe	Use clear and concrete terms to describe what you want. *Don't say:* "Could you please clean?" *Do say:* "Could you do the dishes before going to bed?"
Express	Let others know how a situation makes you feel by clearly expressing your feelings. Don't expect others to read your mind. Try using this line: *"I feel because_."*
Assert	Don't beat around the bush—say what you need to say. *Don't say:* "Oh, well, I don't know if I can cook tonight or not." *Do say:* "I won't be able to cook because I'm working late."
Reinforce	Reward people who respond well, and reinforce why your desired outcome is positive. This can be as simple as a smile and a *"thank you"*.
Mindful	Don't forget the objective of the interaction. It can be easy to get sidetracked into harmful arguments and lose focus.
Appear	Appear confident. Consider your posture, tone, eye contact, and body language.
Negotiate	No one can have everything they want out of an interaction all the time. Be open to negotiation. *Do say:* "If you wash the dishes, I'll put them away."

Appendix 5

Interpersonal Effectiveness Skills

Relationship Effectiveness (G.I.V.E.)

Relationships aren't only about getting what we need—they're also about the other person. The acronym *G.I.V.E.* will help you achieve *relationship effectiveness* by fostering positive interactions.

Gentle	Don't attack, threaten or express judgment during your interactions. Accept the occasional "no" for your requests.
Interested	Show interest by listening to the other person without interrupting.
Validate	Be outwardly validating to the other person's thoughts and feelings. Acknowledge their feelings, recognize when your requests are demanding, and respect their opinions.
Easy	Have an easy attitude. Try to smile and act lighthearted.

Self-Respect Effectiveness (F.A.S.T.)

Sometimes in relationships you might find yourself betraying your own values and beliefs to receive approval or to get what you want. The acronym F.A.S.T. will help you achieve *self-respect effectiveness.*

Fair	Be fair. Not only to others, but also to yourself.
Apologies	Don't apologize unless it's warranted. Don't apologize for making a request, having an opinion, or disagreeing.
Stick to Values	Don't compromise your values just to be liked or to get what you want. Stand up for what you believe in.
Truthful	Avoid dishonesty such as exaggeration, acting helpless as a form of manipulation, or outright lying.

Appendix 6

Distress Tolerance Skills

Radical Acceptance

Sometimes you'll run into a problem that's simply out of your control. It can be easy to think "This isn't fair" or "I shouldn't have this problem", even though those ways of thinking only make the pain worse.

Radical acceptance refers to a healthier way of thinking during these situations. Instead of focusing on how you would like something to be different, you will recognize and accept the problem or situation as it is. Remember, accepting is not the same as liking or condoning something.

Learning to accept the problems that are out of your control will lead to less anxiety, anger, and sadness when dealing with them.

Situation	
You find out that you were not selected for a job where you felt that you were the best candidate.	
Typical Thinking	Radical Acceptance
"This isn't fair—I did everything right! I was the best one there. They can't do this to me."	"It's frustrating that I didn't get the job, but I accept that they felt someone else would be a better fit."

Self-Soothe with Senses

Find a pleasurable way to engage each of your five senses. Doing so will help to soothe your negative emotions.

Vision	Go for a walk somewhere nice and pay attention to the sights.
Hearing	Listen to something enjoyable such as music or nature.
Touch	Take a warm bath or get a massage.
Taste	Have a small treat—it doesn't have to be a full meal.
Smell	Find some flowers or spray a perfume or cologne you like.

Appendix 7

Distress Tolerance Skills

Distraction (A.C.C.E.P.T.S.)

Negative feelings will usually pass, or at least lessen in intensity over time. It can be valuable to distract yourself until the emotions subside. The acronym "*A.C.C.E.P.T.S.*" serves as a reminder of this idea.

Activities	Engage in activities that require thought and concentration. This could be a hobby, a project, work, or school.
Contributing	Focus on someone or something other than yourself. You can volunteer, do a good deed, or do anything else that will contribute to a cause or person.
Comparisons	Look at your situation in comparison to something worse. Remember a time you were in more pain, or when someone else was going through something more difficult.
Emotions	Do something that will create a competing emotion. Feeling sad? Watch a funny movie. Feeling nervous? Listen to soothing music.
Pushing Away	Do away with negative thoughts by pushing them out of your mind. Imagine writing your problem on a piece of paper, crumbling it up, and throwing it away. Refuse to think about the situation until a better time.
Thoughts	When your emotions take over, try to focus on your thoughts. Count to 10, recite a poem in your head, or read a book.
Sensations	Find safe physical sensations to distract you from intense negative emotions. Wear a rubber band and snap it on your wrist, hold an ice cube in your hand, or eat something sour like a lime.

Appendix 8

EMOTION REGULATION WORKSHEET

Identifying the Function of the Emotion

Identify an emotional reaction (lasting a few moments to a few minutes) during the week and describe the following:

1. What was the prompting event?

2. What was your interpretation?

3. What was the emotion and intensity (0-100)?

4. Use the following to identify the function(s) of the emotion:

    a. Did the emotion communicate something to others or influence their behavior? If so, describe:

    b. Did the emotion organize or motivate you to do something? If so, describe:

    c. Did the emotion give you information, color your perception, or lead you to any conclusions? If so, describe:

Seth R. Axelrod, PhD, 4-23-2004 adapted from Marsha Linehan's (1993) *Skills Training Manual for Treating Borderline Personality Disorder.*

The Columbia- Suicide Severity Scale

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Pediatric - Since Last Contact – Communities and Healthcare

Version 6/23/10

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in ***The Columbia Suicide History Form,*** *developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.]* Standardized Evaluation in Clinical Practice, *pp. 103 -130, 2003.)*

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact *posnerk@nyspi.columbia.edu*

SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

Since Last Visit

1. Wish to be Dead
Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.
Have you thought about being dead or what it would be like to be dead?
Have you wished you were dead or wished you could go to sleep and never wake up?
Do you wish you weren't alive anymore?

If yes, describe:

Yes ☐ **No** ☐

2. Non-Specific Active Suicidal Thoughts
General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.
Have you thought about doing something to make yourself not alive anymore?
Have you had any thoughts about killing yourself?

If yes, describe:

Yes ☐ **No** ☐

3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act
Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."*
Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?

If yes, describe:

Yes ☐ **No** ☐

4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan
Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."*
When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?
This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.

If yes, describe:

Yes ☐ **No** ☐

5. Active Suicidal Ideation with Specific Plan and Intent
Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.
Have you decided how or when you would make yourself not alive anymore/kill yourself? Have you planned out (worked out the details of) how you would do it?
What was your plan?
When you made this plan (or worked out these details), was any part of you thinking about actually doing it?

If yes, describe:

Yes ☐ **No** ☐

INTENSITY OF IDEATION

The following feature should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe).

Most Severe Ideation: _____ _____

Type # (1-5) ***Description of Ideation***

Most Severe

Frequency
How many times have you had these thoughts? ***Write response***_____
(1) Only one time (2) A few times (3) A lot (4) All the time (0) Don't know/Not applicable

____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Since Last Visit**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Did you do anything to try to kill yourself or make yourself not alive anymore? What did you do?*** ***Did you hurt yourself on purpose? Why did you do that?*** ***Did you_____as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to make yourself not alive anymore when you_____?*** ***Or did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, or get something else to happen)? (***Self-Injurious Behavior without suicidal intent) If yes, describe:	**Yes No** ☐ ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	**Yes No** ☐ ☐
Has subject engaged in Self-Injurious Behavior, intent unknown?	**Yes No** ☐ ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?*** If yes, describe:	**Yes No** ☐ ☐ Total # of interrupted
Aborted Attempt or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?*** If yes, describe:	**Yes No** ☐ ☐ Total # of aborted or self-interrupted
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?*** If yes, describe:	**Yes No** ☐ ☐ Total # of preparatory acts
Suicide: Death by suicide occurred since last assessment.	**Yes No** ☐ ☐
	Most Lethal Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code*

Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____

Informed Consent

Comité de Ética de Investigación en Seres Humanos Universidad San Francisco de Quito

El Comité de Revisión Institucional de la USFQ The Institutional Review Board of the USFQ

Formulario Consentimiento Informado

Título de la investigación: La efectividad de la Terapia Dialéctica Conductual para reducir la frecuencia e intensidad de la ideación suicida y las conductas suicidas en individuos con trastorno de personalidad limítrofe

Organización del investigador Universidad San Francisco de Quito

Nombre del investigador principal Camila Hanann Elmer Intriago

Datos de localización del investigador principal

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Co-investigadores no aplica

DESCRIPCIÓN DEL ESTUDIO
Introducción
Usted ha sido invitado a participar en una investigación sobre la aplicación de la Terapia Dialéctica Conductual para individuos con personalidad limítrofe. El propósito de esta investigación es analizar la efectividad de la Terapia Dialéctica Conductual para reducir la frecuencia e intensidad de la ideación suicida y las conductas suicidas en individuos con este trastorno de personalidad. Los participantes de esta investigación deben cumplir con el diagnóstico de personalidad limítrofe, deben ser mayores a 18 años, tener por lo menos 8 años de educación formal y no deben estar participando en otras formas de tratamiento o tener deterioro cognitivo. Se puede hacer cualquier tipo de pregunta para aclarar este estudio y su participación.
Propósito del estudio
El propósito de esta investigación es analizar la efectividad de la Terapia Dialéctica Conductual para reducir la frecuencia e intensidad de la ideación suicida y las conductas suicidas en individuos con personalidad limítrofe. A los participantes se les proporcionara todas las herramientas y pautas necesarias de la terapia, con el fin de recudir estos pensamientos y comportamientos. Las intervenciones se manejaran en sesiones semanales tanto individuales como grupales.
Descripción de los procedimientos

En la etapa inicial se tomará el cuestionario The Columbia-Sucide Severity Rating Scale para medir y analizar el la frecuencia e intensidad de la ideación suicida y de los comportamientos suicidas y la posible mortalidad.

La segunda fase consiste en iniciar la intervención durante seis meses y volver a tomar el cuestionario el test analizar resultados.

La tercera etapa se realiza al culminar el programa a los doce meses del tratamiento, nuevamente se aplicara el cuestionario para evidenciar los resultados.

Riesgos y beneficios

Los riegos que se podrían presenciar son problemas emocionales y dificultades interpersonales con los demás participantes del grupo. Sin embargo, se espera que sea beneficioso al ayudar a los participantes a adquirir habilidades necesarias para manejar distintas situaciones individuales y grupales.

Confidencialidad de los datos

Es muy importante mantener la privacidad, por lo cual se aplicaran las medidas necesarias para que permanezca anónimo y que nadie tenga acceso a su información personal.

1) La información que nos proporcionara se identificará con un código que reemplazará su nombre y se guardará en la residencia del investigador donde solo ese individuo tendrá acceso.

2) Durante las sesiones grupales se le asignara un alias, para que no se lo pueda identificar durante o posterior a la investigación.

3) Si usted está de acuerdo, los resultados que se obtengan de su persona serán utilizadas para esta investigación y luego se las guardarán para futuras investigaciones removiendo cualquier información que pueda identificarlo

4) Su nombre no será mencionado en los reportes o publicaciones.

5) El Comité de Bioética de la USFQ podrá tener acceso a sus datos en caso de que surgieran problemas en cuando a la seguridad y confidencialidad de la información o de la ética en el estudio.

Derechos y opciones del participante

Si usted decide no participar solamente debe informar al investigador principal. Si decide participar y durante la investigación decide que no desea continuar puede retirarse del estudio en cualquier momento.

No recibirá ningún tipo de pago y tampoco tendrá que pagar para participar en la investigación.

Información de contacto

Si usted tiene alguna pregunta sobre el estudio por favor contactarse al siguiente teléfono 0995654593 que pertenece a Camila Hanann Elmer Intriago, o enviar un correo electrónico a camilaelmer@gmail.com
Si usted tiene preguntas sobre este formulario puede contactar al Dr. Iván Sisa, Presidente del Comité de Ética de Investigación en Seres Humanos de la USFQ, al siguiente correo electrónico: comitebioetica@usfq.edu.ec

Consentimiento informado	
Comprendo mi participación en este estudio. Me han explicado los riesgos y beneficios de participar en un lenguaje claro y sencillo. Todas mis preguntas fueron contestadas. Me permitieron contar con tiempo suficiente para tomar la decisión de participar y me entregaron una copia de este formulario de consentimiento informado. Acepto voluntariamente participar en esta investigación.	
Firma del participante	Fecha
Firma del testigo *(si aplica)*	Fecha
Nombre del investigador que obtiene el consentimiento informado	
Firma del investigador	Fecha