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Counselors' Spirituality, Attitudes Toward Suicide, and Self-Efficacy in Conducting Suicide Risk Assessment

Abstract

The present study aimed to explore the relationship between perceived spiritual support and counselor self-efficacy in conducting suicide risk assessment, and the moderating effects of attitudes about suicide on this relationship. Based on existing theory and empirical evidence, perceived spiritual support was hypothesized to have a positive predictive relationship with counselor self-efficacy in performing suicide risk assessment; further, four different constructs pertaining to attitudes toward suicide were also hypothesized to moderate the strength and direction of this relationship. A sample of Master's level clinicians and advanced standing Master's graduate students (N=132) completed an online survey containing instruments measuring perceived spiritual support (predictor), counselor self-efficacy in suicide risk assessment (dependent variable), and four constructs within attitudes toward suicide (moderators), including avoidance of communication, suicide as common, suicide as acceptable, and preventability of suicide. Multiple moderated regression analyses were performed using SPSS 26.0. Different than hypothesized, three of the four attitudes measured (common, acceptable, and preventable) did not significantly moderate the relationship between the predictor and outcome. However, as estimated, higher levels of perceived spiritual support predicted increased counselor self-efficacy scores. Further, avoidance of communication attitudes were found to weaken this predictive relationship. Limitations and implications for future research and practice are discussed.

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First Advisor

Julia Roncoroni

Second Advisor

Carrie Doehring

Third Advisor

Lisa Brownstone

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Tayler Hendrix, M.A.

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Advisor: Julia Roncoroni, Ph.D.

Author: Tayler Hendrix, M.A.
Title: Counselors' Spirituality, Attitudes Toward Suicide, and Self-Efficacy in
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ABSTRACT

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Chapter One: Literature Review

Suicide is a public health issue in the United States that occurs at alarming rates (Centers for Disease Control and Prevention, 2021b; National Institute of Mental Health, 2019). Suicide is defined by the NIMH as “death caused by self-directed injurious behavior with intent to die as a result of the behavior” (National Institute of Mental Health, 2019). In 2019, suicide claimed the lives of over 47,500 people in the U.S., while an additional 12 million adults reported having suicidal thoughts, 1.4 million attempted suicide, and 3.5 million planned an attempt (Centers for Disease Control and Prevention, 2021b). Practicing therapists are frequently confronted with patients struggling with suicidal thoughts, feelings, and behaviors (Binkley & Leibert, 2015). Furthermore, nearly all clinicians will treat at least one suicidal patient throughout the course of their careers (Binkley & Leibert, 2015; Douglas & Morris, 2015). Therefore, risk assessment is one of the most critical areas of clinical work and a skill all therapists ethically need to be well-versed in; yet, current research shows a lack of counselor confidence and self-efficacy in conducting risk assessment and treating suicidal patients (Gallo, 2016, 2018).

The generalized lack of counselor self-efficacy is important given that existing empirical research is finding more and more evidence for positive relationships between counselor self-efficacy in assessing suicide risk and counselor competence (Barnes, 2004; Gallo, 2018). Gallo (2018) also found a positive association between counselor suicide assessment self-efficacy and frequency of assessments performed; greater numbers of

assessments mean more opportunities to identify risk factors, implement prevention strategies, and possibly help someone struggling with suicidality (Gallo, 2018).

Existing research has looked at possible contributing factors for self-efficacy in risk assessment, such as attitudes toward suicide, but not how these attitudes may intersect with personal factors to impact counselor self-efficacy in working with suicidal clients (G. Elliott et al., 2018). Gaining a better understanding of the multi-faceted nature of counselor self-efficacy has the potential to help positively inform curriculum development, education, and suicide-prevention training. In order to better understand what contributes and possibly moderates counselor self-efficacy in conducting risk assessment, it is necessary to explore relationships among personal and professional factors already shown to impact confidence in counselors' abilities.

Suicide as a Public Health Concern in the US

Suicide is the tenth leading cause of death in the United States (Centers for Disease Control and Prevention, 2019a). Recent reports also show rates of suicide in the United States appear to have increased from 2020 to 2021 by approximately 4% (Curtin & Ahmad, 2022). Addressing the prolific impact of suicide requires suicidality and suicide prevention efforts to be taken seriously (Centers for Disease Control and Prevention, 2019a; National Institute of Mental Health, 2019).

Emerging Trends

Around the world, over 700,000 individuals die by suicide annually (World Health Organization, 2021). The United States in particular saw an overall drastic 33% increase in suicide rates from 1999-2019; however, researchers found that this rate decreased for the first time since the early 2000s from 2018 to 2019 (Centers for Disease

Control and Prevention, 2019a; National Institute of Mental Health, 2019). The United States also saw a significant decrease in 2019 suicide rates for both men and women (Centers for Disease Control and Prevention, 2021b). Unfortunately, national suicide counts began to once again increase between 2020 and 2021 (from 45,979 to 48,183) (Centers for Disease Control and Prevention, 2023; Curtin & Ahmad, 2022).

Additionally, Stone, Jones, and Mack (2021) found that while firearms continue to be the most common means used in suicide deaths (accounting for over half nationally), the United States has seen an overall decrease in the use of this highly lethal mechanism (Centers for Disease Control and Prevention, 2021, 2023). Current reports show suicide by firearm to account for over half of male suicides and over 30% of female suicides (National Institute of Mental Health, 2022). The second most common manner of suicide was suffocation, accounting for 28.4% of deaths by suicide among males, and poisoning, accounting for 30% of deaths by suicide among females (Centers for Disease Control and Prevention, 2019, 2023; National Institute of Mental Health, 2019).

Despite national suicide rates decreasing in 2019 and 2020, it is challenging to predict how these rates will change over the next decade as researchers continue to work on understanding the long-term impacts the coronavirus pandemic will have on those in the United States (National Institute of Mental Health, 2022). Preliminary reports from the U.S. National Center for Health Statistics showed a 5.6% decrease in U.S. suicide rates in 2020 before the 4% increase in 2021 (Ahmad & Anderson, 2021; Centers for Disease Control and Prevention, 2023; National Institute of Mental Health, 2022).

Utilizing data from the Massachusetts Department of Public Health, a recent cohort study assessing suicide rates during the stay-at-home order also found no increase in suicides

through the spring of 2020 (Faust et al., 2021). However, both studies utilized data from early on in the COVID-19 pandemic, making it difficult to predict how these mental health patterns may fluctuate over time (Carballeira, 2021). Research conducted following Hurricane Katrina demonstrated that suicide rates tend to rise after maintaining stability during the disaster itself (Kessler et al., 2008). The United States saw this come to fruition as suicide rates rose in 2021 (Centers for Disease Control and Prevention, 2023; Curtin & Ahmad, 2022). This suggests a need for counselors to prepare for an increase in suicidality in the coming years as the population works to survive COVID-19 and associated consequences. Assessing the impact the pandemic continues to have on suicidality for both national and international populations will be an essential area of future research.

At-Risk Populations

Certain subgroups within the United States are at a higher risk for dying by suicide than the general population (Centers for Disease Control and Prevention, 2021b). This risk is dependent on a number of intersecting identity and experiential factors such as race/ethnicity, gender, age, and trauma history (National Institute of Mental Health, 2019; Ports et al., 2017; Ramchand et al., 2021). Current suicide data show rates are highest for Non-Hispanic American Indian adults (28.1 suicide deaths per 100,000 people) (Centers for Disease Control and Prevention, 2019, 2023). Reports from the previous five years also continue to show the second highest rates are among non-Hispanic White individuals (17.4 suicide deaths per 100,000 people) (Centers for Disease Control and Prevention, 2019, 2023).

Racial and ethnic health disparities are prevalent throughout the United States and exist within the reported rates of suicide (Ramchand et al., 2021). Stone, Jones, & Mack's (2021) report found that while overall suicide rates for men and women in the U.S. had declined in 2019 and early 2020 for non-Hispanic Whites, they had not for other racial/ethnic groups (Centers for Disease Control and Prevention, 2021b). Moreover, preliminary studies conducted during the COVID-19 pandemic indicate that, while the number of suicides fell overall in 2020, rates appear to have gone up among people of color (Bray et al., 2020; Illinois Department of Public Health, 2021; T. O. Mitchell & Li, 2021). States including Illinois, Maryland, and Connecticut unanimously observed an overall decrease in suicide rates and significant reduction in suicide rates among Whites; however, rates for BIPOC communities had steadily risen, particularly in Black communities (Bray et al., 2020; Illinois Department of Public Health, 2021; T. O. Mitchell & Li, 2021).

Gender is an important factor to consider when assessing for suicide risk, as males throughout the lifespan are at a higher risk for dying by suicide than females (Centers for Disease Control and Prevention, 2023a, 2023b; Curtin & Ahmad, 2022; National Institute of Mental Health, 2022). Though females have a higher likelihood of attempting suicide, males more frequently die by suicide due to use of more lethal means (i.e., firearms) (Centers for Disease Control and Prevention, 2021, 2023; National Institute of Mental Health, 2019). Men near retirement age and above the age of 75 are at an especially high risk for dying by suicide (Centers for Disease Control and Prevention, 2023). It is important for clinicians to be aware that suicide rates in this particular group (older men)

have been steadily rising over the last decade (Centers for Disease Control and Prevention, 2019a, 2021b; National Institute of Mental Health, 2019).

The CDC (2021) and National Institute of Mental Health (2019) also show substantial disparities in suicide rates among different age groups in the United States. In addition to men above the age of 75, suicide continues to be a leading cause of death among men and women between the ages of 45-64 (Centers for Disease Control and Prevention, 2021, 2023). In addition, suicide is the second most common cause of death among children and adolescents in the United States (Centers for Disease Control and Prevention, 2023). Though suicide rates are relatively low in the 10-14 age range, these numbers jump significantly once individuals enter into the 15-24 age range (Centers for Disease Control and Prevention, 2019, 2021).

Significant concern arises when looking at suicide rates from an intersectional perspective, especially for youth of color. Overall, American Indian youth have the highest rates of dying by suicide among children and adolescents in the United States (Ramchand et al., 2021). Assessment of recent suicide rates among racial and ethnic subgroups within the U.S. showed an increase in suicide among both Black and Asian/Pacific Islander adolescents (Ramchand et al., 2021). Between 2013-2019, the U.S. saw a 59% increase in suicide among Black female youth, a 47% increase among Black male youth, a 42% increase in rates among Asian female youth, and a 40% increase among Asian male youth (Ramchand et al., 2021). It is hypothesized these observed suicide rates in youth are due to issues related to mental health, racism, trauma, and stress (Sheftall et al., 2021).

There is a substantial predictive relationship between adverse childhood experiences and suicidality (Dube et al., 2001; Ports et al., 2017). Adverse childhood experiences (ACEs) are defined as possibly traumatic events experienced before the age of 18, such as abuse or neglect (Centers for Disease Control and Prevention, 2021a). A recent study showed that adults who experienced ACEs have a greater likelihood of suicide attempts during their lifetime (Choi et al., 2017). Adults in the United States who experienced ACEs also have increased rates of suicidal ideation and consideration of suicide (Thompson et al., 2019). Adverse childhood experiences become even more detrimental to long-term health as they accumulate; adults who have experienced at least three ACEs are more than three times as likely to struggle with suicidality (Thompson et al., 2019). It is necessary for clinicians and suicide prevention approaches to include recognition of child abuse, neglect, and trauma as major risk factors for suicidality (Ports et al., 2017).

Clinicians must also understand the increased rates of suicide and self-harm in sexual and gender minority populations, particularly LGBTQIA+ youth, who are two to three times more likely to struggle with suicidality than their peers (Centers for Disease Control and Prevention, 2023; Gnan et al., 2019). Those who identify as part of the LGBTQIA+ community often face bullying and harassment that negatively impacts mental health and well-being (Centers for Disease Control and Prevention, 2019, 2023). The Trevor Project (2021) estimates that every 45 seconds, an LGBTQIA+ youth in the U.S. attempts suicide. Queer adult men are also at an increased risk for suicide attempts (Centers for Disease Control and Prevention, 2019b). Furthermore, data from the 2015

U.S. Transgender Survey show a greater frequency of suicide attempts and ideation among trans adults when compared to the general population.

Certain populations have become more at-risk for suicide as a result of the COVID-19 pandemic; examples include the elderly, racial/ethnic minority groups, individuals from rural regions, school-aged children, socio-economically disadvantaged individuals, and people living in dangerous home environments (Centers for Disease Control and Prevention, 2023; Moutier, 2021). Many of these people have been faced with great levels of social isolation, loneliness, and uncertainty, all of which impact individuals' mental health and well-being (Klomek, 2020; Moutier, 2021). Evidence also suggests clinicians must holistically consider how a client's intersecting identities influence their experiences of trauma and suicidality in order to uphold best practice strategies for suicide prevention (Hofstra et al., 2020; Moutier, 2021). Thus, it is especially necessary for therapists to recognize the possible compounding effects of suicide risk factors within at-risk groups (Moutier, 2021).

Attitudes Toward Suicide

Attitudes can be understood as how we feel about something, in this case, the phenomenon of suicide (Jeon et al., 2013; Jiao et al., 2014; Norheim et al., 2016), while beliefs represent the cognitive foundation for an attitude; these terms are not the same, nor are they mutually exclusive (Richardson, 1996). Attitudes, the focus of this study, have the ability to mediate or moderate the relationships between certain personal and professional factors and interventions used by therapists in their clinical work (Aherne et al., 2018; Osteen et al., 2017). Exploration of attitudes toward suicide in the general population revealed a ten-factor model to describe this latent variable (Renberg &

Jacobsson, 2003); however, when assessing mental health professionals in particular, four primary domains (factors) of attitudes toward suicide were identified through use of the ATTS questionnaire developed by Renberg and Jacobsson in 2003 (Norheim et al., 2016). Therefore, for the purpose of this study, the central facets of attitudes toward suicide can be understood as the following: avoidance of communication, permissive/accepting, common, and preventable (Norheim et al., 2016).

These four subconstructs of attitudes toward suicide are particularly important to assess in the context of suicide risk assessment provision. The *avoidance of communication* factor is defined as the belief that discussing suicide triggers suicidality (Norheim et al., 2013, 2016). The *permissive/accepting* factor can be classified as the understanding of suicide as an individual's right, and acceptance of suicide in situations with extenuating circumstances (i.e., when someone is dying of a terminal illness) (Jeon et al., 2013; Norheim et al., 2013, 2016). The *common* factor refers to the idea that suicidality is an understandable and common experience for individuals (Jiao et al., 2014; Norheim et al., 2013, 2016). Finally, the *preventable* factor is defined as the notion that suicide can and should be prevented (Jiao et al., 2014; Norheim et al., 2013, 2016). It is important to note that permissive/accepting and unaccepting attitudes are not always inherently good or bad, right or wrong, nor are they mutually exclusive from one another; the importance lies with how these attitudes impact a counselor's self-efficacy and clinical practices (Gagnon & Hasking, 2012).

Various factors can influence one's attitudes toward suicide including stigma and religious beliefs (Na et al., 2018). Research has also demonstrated that characteristics including a person's experiences with death and spiritual affiliation impact an

individual's attitude toward suicide (Cramer et al., 2013). The Harris Poll was commissioned by the American Foundation for Suicide Prevention, the National Action Alliance for Suicide Prevention, and the Suicide Prevention Education Development Center to explore and learn more about current public perceptions of suicide in the United States' general population (Harris Poll, 2022). According to survey results, the vast majority of U.S. adults believe that suicide can be prevented (Harris Poll, 2020, 2022). Of the respondents, 94% reported feeling that suicide is preventable at least sometimes, while 52% reported feeling suicide was often or always preventable; these data represent a hopeful change, as both of these percentages have continuously risen since 2019 (Harris Poll, 2022).

A harmful attitude that leads to avoidance exists among the general population and among mental health professionals that talking about suicide may induce suicidal thoughts and behaviors (Dazzi et al., 2014). Research demonstrates that talking about suicide does not increase the likelihood of suicidal thoughts and behaviors, both for the general population and at-risk populations (Dazzi et al., 2014). Existing research actually suggests the opposite is true, that talking about suicide may come with a number of life-saving benefits (Dazzi et al., 2014). Inviting in conversations regarding suicidality have been shown not only to help reduce experiences of suicidal ideation, but also led to overall improvements in mental health outcomes (i.e., reduction in symptoms and risk) (Dazzi et al., 2014). Thus, it is important to explore clinicians' attitudes and beliefs around avoidance of communication regarding suicide (Norheim et al., 2016). Clinicians that endorse the notion that suicide should not be discussed risk missing crucial details that may speak to a client's current functioning and overall level of acuity (Dazzi et al.,

2014; Norheim et al., 2013). Failing to gather this important information can hinder the provision of competent, thorough risk assessment and neglects client safety (Cramer et al., 2013; Dubue & Hanson, 2020; Martinengo et al., 2019).

Research conducted with international populations in Shanghai has suggested mental health professionals have a stronger belief in suicide preventability when compared to the general population (Jiao et al., 2014). Therapists do not tend to hold stigmatizing attitudes toward suicidal individuals, such as suicidality being a sign of weakness (Groth & Boccio, 2019). In fact, past and current literature suggest that maintaining the attitudes that suicide is preventable and that clinicians have the power to help keep suicidal clients safe may lead to more proactive and quality risk assessment intervention (Douglas & Morris, 2015; Werth & Liddle, 1994). However, several studies have established an overall pattern of pessimistic attitudes among mental health practitioners toward working with clients who engage in self-harm or demonstrate suicidal behaviors (Groth & Boccio, 2019; Saunders et al., 2012).

Early research exploring therapists' attitudes toward suicide revealed some clinicians believe suicide to be immoral (Albright, 1994). These unaccepting attitudes toward suicide appear to be especially prevalent among clinicians who report regularly attending religious services (Kennedy, 2010). Such research has been limited by the use of single-item measures, such as attending religious services, that do not measure the complexity of spiritual and moral orientations to suicide, which are "made up of a myriad of thoughts, feelings, actions, experiences, relationships, and physiological responses which serve many purposes and yield a number of consequences" (Pargament et al., 2013, p. 5). Other factors that make counselors less willing to work with new

patients who are suicidal are concerns of competence, lack of resources, and negative attitudes toward suicidal patient outcomes (Groth & Boccio, 2019). However, clinicians with greater experience treating suicidal clients have been shown to demonstrate more empathetic and positive attitudes toward suicide (Gagnon & Hasking, 2012). No current research is available regarding whether mental health professionals in the U.S. specifically have a greater belief in preventability than the general population, despite this concept's importance.

The attitude that suicidality is a common experience is endorsed not only by clinicians, but also the CDC (Aherne et al., 2018; Centers for Disease Control and Prevention, 2021b). Recent empirical research suggests mental health professionals may have stronger attitudes that suicide is common compared to nurses or physicians (Norheim et al., 2016). Accepting that suicidal thoughts and behaviors are common may help clinicians be able to empathize with clients and normalize their difficult experiences (Aherne et al., 2018). If clinicians see suicide as common and recognize the frequency in which suicidality occurs in the U.S., this has the potential to help therapists recognize the need to be trained in adequately assessing suicide risk (Aherne et al., 2018; Cramer et al., 2013; Norheim et al., 2016). This attitude may also encourage clinicians to more frequently assess for suicide risk and display less judgement when conducting risk assessment (Aherne et al., 2018; Cramer et al., 2013). Therefore, it is important to explore how this attitude impacts a clinician's self-efficacy in conducting risk assessment.

Previous experiences and personal connections to suicide help to shape one's attitudes toward suicide (Joosten, 2020). Certain factors, including therapists' attitudes

about suicide, also influence the appropriateness of suicide interventions used in practice (Neimeyer et al., 2001; Werth & Liddle, 1994). For example, recent empirical evidence demonstrated a positive relationship between clinicians who support the right to suicide and clinical competence, suggesting the attitude that suicide is acceptable is related to a counselor's ability to effectively work with suicidal clients (Joosten, 2020). Though older literature suggests therapy providers who are considered more "accepting" as defined above may be less likely to take action when a client is suicidal (Werth & Liddle, 1994). Decreased frequency in conducting risk assessments has the ability to negatively impact a clinician's confidence and competence in practicing these interventions (Douglas & Morris, 2015). Therefore, additional research is needed to understand how attitudes toward suicide feature among clinicians and how these attitudes impact self-efficacy in clinical practice, especially in relationship to other provider identity and experiential factors.

Suicide Prevention

Suicide prevention efforts began to gain traction in the United States around the mid-1900s, though it took time for legislature to be formally enacted (World Health Organization, 2018). In 2002, the Suicide Prevention Resource Center was crafted to encourage a national strategy for addressing and preventing suicide (World Health Organization, 2018). A critical step toward preventing youth suicide was taken in 2005 when Congress passed the Garrett Lee Smith Memorial Act, which has since been shown to have reduced the numbers of suicide attempts and suicides in young adolescents (World Health Organization, 2018). More recently in 2010, the National Action Alliance

for Suicide Prevention led the country in designing an updated strategy to prevent suicide within the general population (World Health Organization, 2018).

Evidenced-based suicide prevention strategies include a multi-tiered approach to assessing suicide risk and intervening properly with suicidal clients (Hofstra et al., 2020). Preventing suicide involves coordinating patient care, accurately determining level of risk, safety planning, providing evidenced-based therapy like CBT or DBT, intervening appropriately in times of crisis, and conducting follow-up outreaches (Brodsky et al., 2018; Doupnik et al., 2020). Means restriction has also been shown to play a crucial role in suicide prevention (Brodsky et al., 2018; Reidenberg & Berman, 2017). Additionally, prevention efforts should include assessment of protective factors, such as social connectedness and interpersonal relationships, when being utilized with suicidal individuals (Costanza et al., 2020). Implementation of the Zero Suicide model has been recognized by the National Action Alliance for Suicide Prevention as current best practice for suicide prevention and involves assessing, taking action, and monitoring patients using evidence-based approaches (Brodsky et al., 2018). Suicide prevention efforts are directly linked to decreased suicide attempts and increased help-seeking behavior when struggling; thus, it is imperative clinicians understand how to utilize suicide prevention interventions within their clinical practice (Doupnik et al., 2020; Hofstra et al., 2020).

The latest research provides substantial evidence for the need for continued prevention efforts aimed at increasing awareness around suicide and destigmatizing mental health care (Stone et al., 2021). Empirical evidence also suggests suicide prevention strategies and assessments being utilized in healthcare settings should be

universal, as this has been shown to help increase awareness among providers, and therefore inform more competent and efficacious clinical practices (Gordon et al., 2020). Additionally in healthcare settings, providers are using electronic health records and risk prediction software, which have been shown to aid in suicide prevention (Gordon et al., 2020). Based on existing research, there is a clear necessity for evidence-based risk assessment and prevention mechanisms to be fully integrated into healthcare settings and for future research to continue exploring feasible and efficacious suicide prevention strategies (Gordon et al., 2020).

An interesting development in the realm of suicide prevention is the potential of smartphones to act as a medium to providing client-centered interventions remotely (Melia et al., 2020). However, it is clear this prospective resource requires significant improvements before it can be considered an effective suicide prevention strategy (Martinengo et al., 2019; Melia et al., 2020). Smartphones have allowed for increased opportunities for social interaction, access to telehealth, and an ability to stay connected throughout the pandemic (Melia et al., 2020; Moutier, 2021). Mobile devices have also provided a way for media campaigns aimed at destigmatizing mental health and encouraging people to seek help to be disseminated to large numbers of people; initial evidence suggests these campaigns may help to combat suicide (Pirkis et al., 2019). Mobile suicide prevention apps have also become a way to increase access to health care and crisis resources; however, many of these apps provide outdated or incorrect information (Martinengo et al., 2019). Robust evidence exists supporting the need for safe practices to be integrated into the mental health apps made available to consumers,

especially if apps are to be used as a means for suicide prevention (Martinengo et al., 2019; Melia et al., 2020).

Recent research assessing the effects of COVID-19 on suicide prevention strategies provides strong evidence for the increase in suicide prevention preparedness among mental health professionals as the pandemic continues to unfold (Klomek, 2020). This is especially true for at-risk client populations such as healthcare workers and parents with children in school (Moutier, 2021). In order to be most efficacious, current suicide prevention strategies must incorporate the assessment of both pre- and post-pandemic risk factors for suicidality (Moutier, 2021). Unique risk factors have developed since the start of COVID-19; clinicians must consider the impact quarantine, lockdown, uncertainty about the future, political tensions, and racial injustices are having on their patients (Klomek, 2020; Moutier, 2021). Thus, there is a convincing call for mental health practitioners to take a holistic approach to understanding client presenting concerns and experiences with trauma in order to best prevent suicide and instill a sense of hope (Klomek, 2020; Moutier, 2021). Furthermore, it is clear folx with lived experiences related to COVID-19 and other individuals from diverse backgrounds should be an integral part of the suicide prevention curriculum and strategy development (Moutier, 2021).

Counseling Competencies for Suicide Risk Assessment

Specific competencies and ethical codes have been developed to inform training and development of counselors (American Counseling Association, 2014; Council for Accreditation of Counseling and Related Educational Programs (CACREP), 2016).

Becoming competent in the assessment and treatment of suicidality is necessary for both the safety of the client and the clinician (C. R. M. McAdams III & Keener, 2008).

Incompetent treatment of suicidal clients can serve as the cause for most malpractice suits and ethical dilemmas; therefore, it is of significant importance that clinicians become well-versed in their designated competencies and ethical standards (C. R. M. McAdams III & Keener, 2008). Certain research in suicide prevention is also focused on identifying a core competency-based suicide risk management training model, one that fully prepares counselors to treat suicidal clients (Cramer et al., 2013).

CACREP and ACA Standards

The Council for Accreditation of Counseling and Related Educational programs (CACREP) set forth competency standards for clinicians in training, including counselor competencies for suicide assessment (2016). In responding to the rising need for suicide risk assessment competency in U.S. clinicians, several demands for strengthening these standards have been made (Binkley & Leibert, 2015). Unfortunately, when CACREP updated their 2009 standards in 2016, they moved from both knowledge and competency standards (competency being the field implementation of said knowledge) to solely knowledge-based, a move condemned by many researchers, clinicians, and psychologists (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2016; Elliott et al., 2018).

Contemplating and determining the approach and interventions utilized with suicidal clients takes significant consideration of ethical decision making and how to best uphold the code set forth by the American Counseling Association (2014). Clinicians must reflect upon and implement limits of confidentiality when assessing level of client

suicide risk and determining whether it is appropriate and ethical to inform others. Clinicians must work to minimize harm and take preventative action when needed (American Counseling Association, 2014). Counselors are also implored to demonstrate awareness of personal values or experiences that may hinder their ability to deliver efficacious, competent, and culturally-respectful treatment (American Counseling Association, 2014). In support of competency, therapists must also be fully aware of state laws and regulations regarding suicide and mandated reporting. Finally, therapists must understand their level of competency when working with high-risk clients and provide consistent and thorough documentation (American Counseling Association, 2014).

Counseling Suicidal Clients

Treating suicidal individuals is a complex, challenging, and common experience for practicing clinicians (Dubue & Hanson, 2020). A national survey of nearly 400 clinicians found that 23% of the sample had lost a client to suicide at some point in their clinical career (McAdams III & Foster, 2000). The vast majority of doctoral level psychology students will also treat at least one suicidal patient by the time of their pre-doctoral internship (DeAngelis, 2008; Dexter-Mazza & Freeman, 2003). Furthermore, clinicians working in community-based settings, such as hospitals or primary care settings, have an even higher likelihood of treating suicidal patients (Larkin & Beauvais, 2010). Many clinicians experience a shared sense of anxiety when treating suicidal patients, which can negatively influence suicide interventions used in practice (Dubue & Hanson, 2020). Adding on to this anxiety, mental health providers were thrust into the provision of telehealth due to the COVID-19 pandemic, forcing many to embrace a brand new therapeutic modality (Finlayson et al., 2021).

Although the vast majority of clinicians will counsel someone struggling with suicidality during their careers, little is understood about the complex and multi-faceted experiences of counselors treating suicidal clients (Dubue & Hanson, 2020). Clinicians feel a strong moral and ethical obligation to do right by their clients and practice beneficence, while also empathizing with the incredibly difficult cognitive and affective experiences their clients are reporting (Albright, 1994; Gagnon & Hasking, 2012). Counselors also have demonstrated strong support for the use of preventative and evidence-based interventions like CBT or SFBT to treat suicidal clients (Brodsky et al., 2018; Dubue & Hanson, 2020; Finlayson et al., 2021). The commonality of both counseling a suicidal client and losing a client to suicide makes understanding the complexities of suicide risk assessment a clear necessity in the field of psychology.

Training Competent and Efficacious Counselors

The following ten evidence-based core competencies are to be utilized in suicide risk assessment training: (1) understanding one's attitude toward suicide and how this impacts clients; (2) adhering to an empathetic and collaborative approach to treatment; (3) understanding how to assess both protective and risk factors; (4) assessing client's present ideation, intent, and plan; (5) accurate ability to determine overall level of risk; (6) creating and working through an empirically-based safety and treatment plan; (7) warning or involving others as necessary; (8) documenting process thoroughly; (9) comprehending the laws, statutes, and ethical codes regarding suicide; (10) and engaging in both self-care and debriefing following work with suicidal clients (Cramer et al., 2013, 2017). These competencies were derived from synthesizing existing theory and literature on established suicide risk assessment competencies (Cramer et al., 2013). Training using

this model was shown to improve counselors' ability to identify competent and appropriate interventions to use when responding to suicidal patients (Cramer et al., 2017). This collection of competencies was also shown to improve performance for both counselors-in-training and seasoned clinicians (Cramer et al., 2017). The model has demonstrated strong internal consistency and validity and should be used to train and assess suicide intervention competency (Cramer et al., 2020).

Research in the field of psychology has assessed whether personal and professional variables predict competency in suicide intervention skills (Neimeyer et al., 2001). For example, permissive/favorable attitudes toward suicide (i.e., right to suicide) and personal experience with suicidality have been shown to predict lower levels of suicide intervention competence (Neimeyer et al., 2001). Additionally, acceptance of death, experience working with suicidal patients, and completion of risk assessment training have all been found to be positively correlated to competent suicide assessment and intervention (Neimeyer et al., 2001). Therapy and the therapeutic relationship offer a life-saving opportunity for suicidal patients, highlighting the importance of efficacious suicide assessment and intervention (Aherne et al., 2018).

Counselor Self-Efficacy in Suicide Risk Assessment

Over the last two decades in particular, research in the field of counseling has begun to assess both general clinical self-efficacy in addition to self-efficacy specific to different clinical interventions (Douglas & Morris, 2015; Lent et al., 2003). Counselor self-efficacy in conducting suicide risk assessment does not necessarily guarantee competence; however, it bridges the gap between knowing necessary counseling skills and actually using them in practice (Douglas & Morris, 2015). Education and training in

suicide risk assessment influences counselor self-efficacy; this self-efficacy directly impacts the quality of clinical care patients receive (G. Elliott et al., 2018). Therefore, it is necessary to explore how counselors develop self-efficacy in treating suicidal patients and how the field of counseling psychology may be able to promote this sense of self-efficacy.

Self-Efficacy and its Development in Counselors

Albert Bandura's research on the concept of self-efficacy during the 1980s fueled a stronger understanding of the necessity for confidence and self-assurance in the workplace. He defined perceived self-efficacy as "people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives" (Bandura, 1994, 71). Bandura (1982) discovered self-efficacy to be an instrumental piece of the learning process that helps facilitate independent completion of learned tasks. Self-efficacy develops from a combination of personal and observational experiences (Bandura, 1982; Daniels & Larson, 2001). Additionally, Bandura showed that those with a greater sense of self-efficacy exhibit greater persistence when faced with a challenging situation or task (Bandura, 1982, 1994).

Certain cultural factors are correlated to higher levels of self-efficacy in both adolescent and adult populations (Fatima et al., 2018). The utilization of religious coping, in addition to religious practices, in the general population were significant predictors of higher levels of self-efficacy (Fatima et al., 2018). Among counseling trainees, a strong correlation has been found between spirituality ratings and counselor self-efficacy scores (Matthews, 2004; Pollock, 2007). The Counselor Self-Efficacy Scale (CSES) as described by Johnson, Baker, Kopala, Kiselica, and Thompson (1989) was used to

measure general levels of self-efficacy in the utilization of counseling skills, though it is important to consider what other realms of counselor self-efficacy this data may expand into, as self-efficacy is tied to competence and performance (Barnes, 2004; G. Elliott et al., 2018; Matthews, 2004). We therefore ask the question; can clinicians' perceived sense of spiritual support predict levels of therapist self-efficacy in suicide risk assessment? What influences the relationship between these phenomena?

When counseling trainees first enter into their graduate training, self-efficacy is markedly low considering there has not yet been an acquisition of new skills (Hill et al., 2008). Hill et al. (2008) found that counseling students' self-efficacy and confidence levels are dynamic throughout training. It is common for confidence to decrease as skills being learned become more difficult and for that confidence to return to higher levels once these new skills are practiced and successfully learned (Hill et al., 2008). Existing research also demonstrates that counselor self-efficacy begins to increase once clinicians have the opportunity to use the skills being learned in lecture within the counseling setting and with actual clients (Kozina et al., 2010). Additionally, current literature demonstrates that having received prior risk assessment training also predicts higher levels of confidence in one's ability to effectively practice risk assessment and intervention (La Guardia et al., 2019).

Importance of Counselor Self-Efficacy

As previously noted, counselor self-efficacy and competence are strongly connected (Barnes, 2004). Albert Bandura's research on self-efficacy posited that individuals with a greater sense of self-efficacy are able to manage situations more effectively, which, for clinicians, means being able to ethically and competently intervene

with patients in their care (Bandura, 1994; Gallo, 2018; Larson & Daniels, 1998). Recent research has also established that stronger counselor self-efficacy in suicide risk assessment is related to less anxious reactions toward clients presenting as suicidal (S. M. Mitchell et al., 2020). Responding to a challenging client in a negative or agitated manner can derail client progress and demonstrates a lack of empathy and understanding; therefore, it is important to understand how counselors can further develop their self-efficacy and decrease their overall anxiety, especially when working with suicidal clients (Clay, 2017).

Recent research has also found therapists who have higher levels of self-efficacy and confidence in their suicide risk assessment and prevention skills are more likely to use evidence-based interventions and best practices in clinical work (LoParo et al., 2019). Additionally, findings from Gallo (2018) revealed that clinicians with greater sense of self-efficacy perform a higher number of suicide assessments each month, which contributes to increased awareness and opportunity for prevention. Finally, a longitudinal study examining the effects of suicide-related trainings on counselors self-efficacy and attitudes showed a positive relationship between suicide risk assessment self-efficacy and both pro-preventional suicide interventions and more positive attitudes toward use of suicide prevention strategies (Osteen et al., 2017). These results suggest that counselor self-efficacy in assessing suicide risk plays a vital role in saving lives and promoting efficacious practice.

Factors Impacting Self-Efficacy in Suicide Assessment

Confidence and competence in therapists working with suicidal clients has been shown to improve as a function of receiving targeted suicide assessment and prevention

training (LoParo et al., 2019). A primary aspect of risk assessment and suicide prevention training is learning how to accurately recognize, identify, and assess individuals who are struggling with suicidality and their level of risk (La Guardia et al., 2019). Gallo (2018) discovered that confidence in one's ability to distinguish and assess suicidal clients was a statistically significant predictor of reported self-efficacy scores. Further evidence for controlling for suicide risk assessment education is provided by Sawyer, Peters, and Willis (2013), who discovered participation in crises intervention preparation training can directly impact M.A. counseling student self-efficacy in managing crisis situations. Students who have taken crisis-prevention courses and practiced suicide assessment and intervention from a theory-based model demonstrate greater levels of confidence in treating suicidal clients and clients in crisis (Sawyer et al., 2013). The primary predictors for self-efficacy in conducting suicide risk assessment are counselors' willingness to conduct risk assessments and comfort identifying suicidal clients, both of which are connected to having received crisis training (Gallo, 2016, 2018; Sawyer et al., 2013).

Recent studies in the field of counseling psychology have worked to continue identifying factors that impact therapist self-efficacy in risk assessment and intervention (Douglas & Morris, 2015; Gallo, 2016, 2018). This research suggests clinicians who have had previous or current experience working on a crisis team demonstrate higher levels of self-efficacy in conducting suicide risk assessment (Gallo, 2016, 2018). Additionally, Douglas and Morris (2015), the developers of the Counselor Suicide Assessment Efficacy Survey (CSAES), found that participants who identified as current graduate students in counseling reported significantly lower levels of self-efficacy in conducting suicide risk assessment and intervention than more experienced faculty members. In order to build

counselor self-efficacy in conducting risk assessment, curriculum development and educational training programs should work to understand what impacts this self-efficacy and what areas clinicians may feel the least confident in; this allows clinicians opportunities to practice a variety of skills, therefore enhancing self-efficacy (Douglas & Morris, 2015). Mental health professionals with lower self-efficacy have a higher likelihood of poor performance in assessing suicide risk; this is concerning because it is known that effective, empirically-based suicide risk assessment and intervention is necessary in preventing suicide (Douglas & Morris, 2015; Gordon et al., 2020).

Seven primary facets of a counselor's internal processes makeup one's self-efficacy in working with suicidal patients, including beliefs, willingness, and attitudes (Elliott et al., 2018). These attitudes have the potential to impact the relationship between counselor self-efficacy in conducting suicide risk assessment and other demographic factors (Elliott et al., 2018; Norheim et al., 2016). Other variables with the potential to partially moderate these relationships include a clinician's ability and available resources to work with suicidal patients, therapists' willingness to treat suicidal clients, and therapists' perceived readiness to address suicidality in the counseling space (Elliott et al., 2018). Counselors have identified the importance of understanding bias and how pre-existing identity factors may impact self-efficacy in conducting risk assessment; however, the identity factors of religiousness and spirituality have not been explicitly explored (Elliott et al., 2018). It is essential for therapists to be aware and comfortable with personal spiritual or religious attitudes and beliefs, especially in relation to bias, as they conduct clinical work (American Counseling Association, 2014; Burke & Miranti, J.G., 1995).

The Connection Between Religiousness, Spirituality, and Suicide

The relationship between religion, spirituality, and suicide is multidimensional, complex, and unique to different individuals, creating a tangled web of connections between religion/spirituality, suicide, and counselor self-efficacy. Before we can begin to understand these relationships more clearly, we must first understand the meaning of religiousness, spirituality, and suicide.

Research on religion and spirituality explores whether and how spiritual and moral orienting systems are helpful or harmful.

A recent qualitative study on spirituality and suicide by Hall (2017, p. 11) draws upon the research of Pargament (2007) and others focusing on how spirituality as an orienting system that includes beliefs, coping practices, attitudes, social networks may play a positive and negative role in suicidal thoughts and behaviors. She defines suicide as “death caused by self-directed injurious behavior with an intent to die as a result of the behavior” (Hall, 2017, p. 12). This aligns with the CDC’s definition: “Suicide is death caused by injuring oneself with the intent to die” (Centers for Disease Control and Prevention, 2021, 1).

Spiritual orienting systems have the power to impact views on suicidality in both “constructive” and “destructive” ways (Hall, 2017, p. 186). While some messages derived from religion regarding suicide can be stigmatizing (e.g., suicide as a sin), religion and spirituality have been shown to act as protective factors to lower an individual’s suicide risk (Hall, 2017). For clinicians, identities and personal attitudes regarding suicide are not necessarily in and of themselves constructive or destructive;

what matters is how these impact ethical and competent clinical practice (American Counseling Association, 2014). For example, existing research out of Oslo exploring attitudes toward suicide with outpatient clinicians located in Norway and Russia showed that mental health professionals who identified as Christian or reported having a Christian background had statistically significant lower rates of endorsing the attitude that suicide is acceptable (Norheim et al., 2013, 2016). As previously indicated, we know these unaccepting attitudes toward suicide have been linked to less competent clinical practice when treating suicidal patients (Joosten, 2020). So, although it seems greater perceived spiritual support may be able to predict higher counselor self-efficacy scores in suicide risk assessment given the many benefits provided by spiritual coping, one wonders if this relationship will be moderated by the clinicians' attitudes toward suicide (Abu-Raiya & Pargament, 2015; Adegbola, 2007; Ano & Vasconcelles, 2005). Further research must be done in order to better understand how these demographic factors impact therapist's self-efficacy in conducting suicide risk assessment, and in turn, their use of evidenced-based suicide interventions.

In the United States, it seems on the surface many individuals are moving toward identifying as spiritual as opposed to religious (Lipka & Gecewicz, 2017). However, experts in the field of the psychology of religion and spirituality pose this may be a result of "religious and spiritual neglect", suggesting there may be a less holistic understanding of religion among the general population (Pargament et al, 2013, 4). This shift is being observed across diverse populations representing different racial and ethnic, political, gender, class, and religious identities (Lipka & Gecewicz, 2017). Data from November of 2022 indicate approximately four in ten U.S. adults participated in at least monthly

religious services (whether in-person or virtual) (Nadeem, 2023) Drawing from this knowledge, it is important to recognize the variable of perceived spiritual support is inherently integrated into both religion and spirituality given the connection between these two concepts (Pargament et al, 2013).

Another development in the field of psychology has been the exploration of religious and spiritual struggles (Exline et al., 2014; Pargament & Exline, 2022; Pargament et al., 1990, 1998). Individuals who use positive spiritual and religious ways of coping with stress often have a greater perceived sense of spiritual support, which can be highly beneficial in times of distress or crisis (Exline et al., 2014; Pargament et al., 1998). Ai et al. developed a measure of perceived spiritual support, which can be understood as the belief that positive outcomes emerge from one's connection with a higher power (Ai et al., 2020). However, spiritual struggles involve struggles with the divine or others, then seeking support becomes problematic and exacerbates stress. (Exline et al., 2014; Pargament et al., 1998). In the context of counseling, religious and spiritual struggles could make it challenging for therapists to make ethical or moral decisions. Clinicians are often faced with difficult situations in counseling, particularly when counseling suicidal clients (Elliott et al., 2018). Considering religious and spiritual struggles have already been shown to be correlated to poor decision-making and health outcomes, it is vital to understand how a clinician's spirituality shapes their experiences suicide risk assessment (Exline et al., 2014). Drawing upon research on how positive spiritual coping enables spiritual integration of spiritual struggles (Pargament & Exline, 2022), one could infer that spiritual support will likely help clinicians identify and then integrate moral and spiritual struggles arising from suicide risk assessment and treatment.

Definition of Terms

Several key terms will be utilized throughout this report to describe concepts salient to suicide risk assessment, spirituality, and counselor self-efficacy.

Perceived Spiritual Support. This is the internal support experienced from one's attitudes they have a close connection with a higher power, which can be defined differently based on religious or cultural values and teachings (Ai et al., 2020).

Self-efficacy. Most notably conceptualized by psychologist Albert Bandura, self-efficacy is considered one's confidence in their ability to successfully and competently complete a task (Bandura, 1982, 1994).

Spirituality. Current psychological research on spirituality and religion describes spirituality as an orienting system:

We can think of the spiritual orienting system as a subset of the larger general orienting system. The spiritual orienting system includes relatively stable patterns of belief, practice, emotion, and relationship linked to the sacred that guide the individual along preferred pathways to significant destinations.

Spiritual orientations take a remarkable variety of forms. Many spiritual orientations are nested within established religious institutions.... However, spiritual orientations can also develop outside of established religious institutions. There are many nontraditional paths to the sacred: yoga, meditation, knitting, gardening, social action, music, and the list goes on....

Like the orienting system more generally, spiritual orienting systems vary in the degree to which they are well integrated and whole, capable of helping people

weather life's ups and downs and find some sense of significance (Pargament & Exline, 2022, pp. 29-30).

Suicide. Death that is caused by intentional self-injury (Centers for Disease Control and Prevention, 2021b; National Institute of Mental Health, 2019).

Purpose of the Present Study

The purpose of the present study is to assess the relationship between perceived spiritual support and counselor self-efficacy in conducting suicide risk assessment, and the moderating effects of attitudes about suicide on this relationship. Gaining understanding around what may impact or contribute to a clinician's self-efficacy in conducting suicide risk assessment is essential in the realms of curriculum development and training as risk assessment is one of the most important skills counselors need to develop (Cramer et al., 2013). Demonstrating the connection between perceived spiritual support and counselor self-efficacy in conducting risk assessment would be an important step towards more informed curriculum and develop training. Considering that attitudes towards suicide impact counselor self-efficacy in assessing suicidality (Elliott et al., 2018), it is necessary to examine their possible moderation effects.

Based on existing theory and literature, this study will test the following hypotheses:

Hypothesis 1) Perceived spiritual support will be a significant positive predictor of counselor self-efficacy in conducting risk assessment.

Hypothesis 2) Having attitudes toward suicide based on the avoidance of communication will partially moderate the relationship between perceived spiritual support and counselor self-efficacy in conducting risk assessment leading to decreased self-efficacy scores.

Hypothesis 3) Attitudes that suicide is acceptable will partially moderate the relationship between perceived spiritual support and counselor self-efficacy in conducting risk assessment, positively impacting counselor self-efficacy scores.

Hypothesis 4) Attitudes that suicide is common will partially moderate the relationship between perceived spiritual support and counselor self-efficacy in conducting risk assessment through increasing self-efficacy scores.

Hypothesis 5) Preventable attitudes toward suicide will also partially moderate the relationship between perceived spiritual support and counselor self-efficacy in conducting risk assessment, resulting in increased counselor self-efficacy.

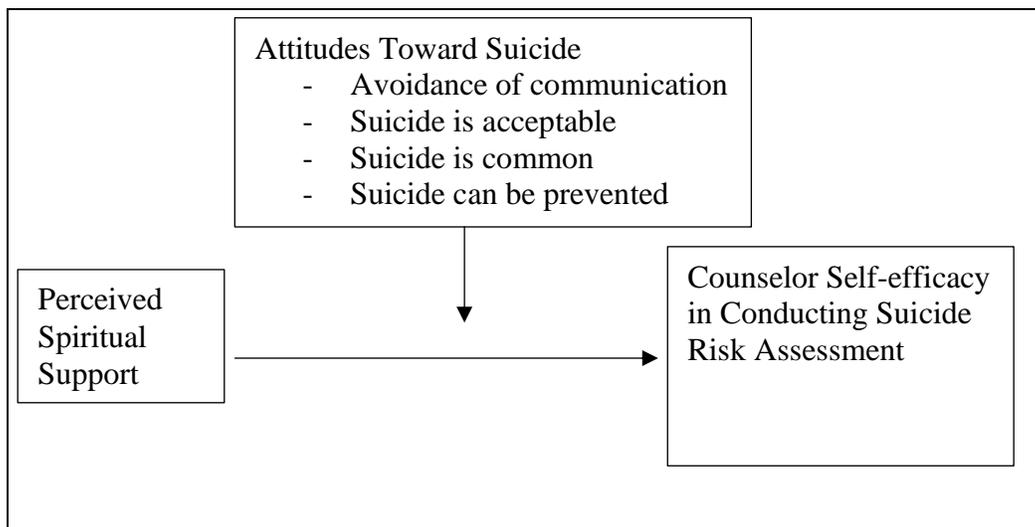


Figure 1. Research Model.

Chapter Two: Method

This cross-sectional survey study was conducted to (a) to better understand the association of perceived spiritual support and counselor self-efficacy in conducting suicide risk assessment (b) and to assess the potential moderating effect that attitudes toward suicide may have on this relationship. The primary independent variable in this study is perceived spiritual support; the dependent variable is counselor self-efficacy in conducting suicide risk assessment. Multiple logistic regression with analysis of moderation effects was used to test the hypotheses. Completion of suicide risk assessment training has been shown to predict greater levels of counselor self-efficacy in conducting suicide risk assessment (La Guardia et al., 2019); thus, this study will control for completion of suicide risk assessment training by restricting participants to those who have received suicide risk assessment training at some point in their education or career (La Guardia et al., 2019). This study will also control for length of time practicing therapy with clients, as experience in the field has been demonstrated to be a predictor of counselor self-efficacy in performing suicide risk assessment (Douglas & Morris, 2015). Given the many psychological benefits of spiritual and religious coping, perceived spiritual support was selected as the primary predictor variable for this study (Abu-Raiya & Pargament, 2015; Ai et al., 2005; Ano & Vasconcelles, 2005). This chapter outlines the participants, data collection procedures, study measures, power analysis, and the strategy for data analysis.

Participants

A total of 132 participants were recruited for this study. Participants were counseling and clinical psychology advanced standing master's level graduate students, Licensed Professional Counselor Candidates (LPCCs), and Licensed Professional Counselors (LPCs). In this context, 'advanced standing' refers to students who have already received risk assessment training and are actively seeing clients in the field. Participants were required to (a) be practicing therapy in the United States, (b) be actively seeing clients, (c) be at least 18 years of age, (d) be able to read and write in English at a 10th grade level (written English will only be necessary if participants select "Other/Please Specify" for any of the demographic questions), and (e) have already received risk assessment training.

Demographic information was collected from participants during survey administration (see Table 1). Participants' racial/ethnic breakdown was as follows: 11.8% Hispanic/Latinx, 7.5% Black, 3.5% Indigenous/Native American, 8.5% Asian/Pacific Islander, 65.2% White, and 3.5% Other (e.g., "Middle Eastern"). Participants ranged in age from 22 to 67, with a mean age of 31.86 years ($SD=10.55$). In terms of gender, participants self-identified in the following ways: 81.6% women, 9.7% men, 5.8% non-binary, 1.9% transgender, and 1.0% other gender identity (e.g., "non-binary woman"). Regarding religious/spiritual affiliation, of the participants surveyed, 44.7% identified as practicing, 34% identified as non-practicing, 15.5% reported no salient religious or spiritual attitude, and 5.8% chose "Other" (e.g., "unsure currently"); 56.3% of all participants reported rarely to never attending religious services as part of their regular practice. Nearly 77% of participants considered themselves to be spiritual, though only

33% considered themselves to be religious. Participant religious/spiritual affiliations were as follows: 12.6% White Evangelical Protestant, 10.7% White Protestant, not Evangelical, 1.9% Black Protestant, 7.8% Catholic, 5.8% Jewish, 1.0% Muslim, 1.0% Hindu, 1.0% Buddhist, and 39.8% Unaffiliated (Atheist/Agnostic). Nearly 17% of participants identified as “Other”, which included Baptist, Christian, Brujeria/witchcraft, Greek Orthodox, LDS, Roma Spiritualism and Episcopal. Finally, participants’ annual household income was reported as follows: 20.4% report less than \$25,000, 24.3% report between \$25,000-\$50,000, 24.3% report between \$50,000 to \$100,000, 21.4% report between \$100,000 to \$200,000, and 7.8% reported over \$200,000 annually.

Table 1. *Participants’ Demographic Information*

	%
Race (multiple answers allowed)	
Hispanic/Latinx	11.8
Indigenous/Native American	3.5
Asian/Pacific Islander	8.5
Black	7.5
Caucasian/White	65.2
Other (e.g., “Middle Eastern”)	3.5
Gender	
Woman	81.6
Man	9.7
Non-binary	5.8
Transgender	1.9

Table 1. *Participants' Demographic Information (cont'd)*
%

Other (e.g., “Non-binary woman”)	1.0
Religious/Spiritual Engagement & Affiliation	
Practicing	44.7
Non-practicing	34.0
No religious/spiritual beliefs	15.5
Other (e.g., “Unsure currently”)	5.8
Identify as “Spiritual”	76.7
Identify as “Religious”	33
White evangelical protestant	12.6
White protestant, not evangelical	10.7
Black Protestant	1.9
Catholic	7.8
Jewish	5.8
Muslim	1.0
Hindu	1.0
Buddhist	1.0
Unaffiliated (Atheist/Agnostic)	39.8
Other (please specify)	16.5
I prefer not to answer	1.9
Annual household income:	
Less than \$25,000	20.4

Table 1. *Participants' Demographic Information (cont'd)*
%

\$25,000-\$50,000	24.3
\$50,000-\$100,000	24.3
\$100,000-\$200,000	21.4
More than \$200,000	7.8
I prefer not to answer	1.9
Age	
22-29 years	44.6
30-39 years	18.9
40-49 years	7.7
50-59 years	2.4
60 or older	3.2

As shown in Table 2, over 83% of participants responded that their graduate training included suicide assessment, while the remainder had to seek external suicide risk assessment training. Almost a third (31.1%) of this study's participants were LPCs; yet, graduate students from different types of programs also made up a significant portion of participants (16.5% Counseling Psychology MA and 29.1% Clinical Mental Health Counseling). At the time of the study, the vast majority of participants were practicing in the Western part of the United States (69.9%), while 19.4% were in the Midwest, 2.9% in the Northeast, and 7.8% in the South. Of those surveyed, 58.3% reported practicing therapy in an urban setting, while 8.7% reported working in a rural setting and 32% in a suburban setting. Providers offered services at the following types of settings: 36.9% in a

community mental health center, 33% in private practice, 4.9% in college counseling centers, 5.8% in schools, 1.9% in substance use treatment centers, and 2.9% in hospitals. Over 14% of participants worked in other settings such as wellness programs and vocational counseling centers. Approximately one quarter of participants reported completing between one to two suicide assessments per month on average, while 43.2% of participants reported completing three or more. Participants' length of experience practicing therapy ranged from two months to 27 years, with 34% of clients reporting having seen clients for about one year. Finally, 35% of participants reported having been part of a crisis team at some point during their professional career.

Table 2. *Participant Professional Information & Risk Assessment Practices*
%

Current title	
Counseling Psychology MA student	16.5
CMHC MA student	29.1
LPCC	12.6
LPC	31.1
Other	10.7
Current counseling setting	
Midwest	19.4
Northeast	2.9
South	7.8
West	69.9
Rural	8.7

Table 2. *Participant Professional Information & Risk Assessment Practices (cont'd)*
%

Suburban	32
Urban	58.3
Other (telehealth)	1.0
Community Mental Health Center	36.9
College Counseling Center	4.9
Private Practice	33.0
Alcohol/Substance Use Center	1.9
Hospital	2.9
School	5.8
Other	14.6
Number of monthly suicide assessments (on average)	
Zero	32.2
One-Two	24.6
Three-Four	12.9
Five-Ten	20.4
More than 10	9.9
Experience as member of a crisis response team	
No	65
Yes	35

Table 2. *Participant Professional Information & Risk Assessment Practices (cont'd)*
%

Graduate training included suicide assessment	
No (had to seek external training)	16.5
Yes	83.5

Procedure

After obtaining approval to conduct this study from my dissertation committee and Institutional Review Board at the University of Denver, I outreached several master's level counseling and clinical psychology training programs and therapy centers in the U.S. in order to recruit participants. I introduced myself to training directors and clinical directors via email and concisely stated the purpose of my outreach. I provided training and clinical directors with a brief overview of the study and asked for their permission to disseminate the survey to students in their programs and employees at their sites. Programs and healthcare centers from all fifty states were outreached for this study. American Psychological Association (APA) Division 17, Division of Counseling Psychology, and Division 36, Society for the Psychology of Religion and Spirituality email listservs were also utilized to enlist participants.

The informed consent form (ICF) and an anonymous online survey containing the study measures (see *Measures* section) were distributed via Qualtrics. The ICF was disseminated to interested participants for independent review before beginning the survey. The ICF detailed the risks and benefits associated with the study, in addition to the study's purpose and procedures. The consent form explained to potential participants that they could decline participation in the study and/or withdraw from the study at any

point, for any reason, without penalty. Participation in this study was completely voluntary. No identifying information was collected from participants; however, if participants wished to enter the optional gift card lottery, an email address was requested. Email addresses were and will not be shared with any outside sources or organizations and were solely used for the purpose of gift card provision. Participants were encouraged to contact the researcher with any questions regarding risks/benefits or the consent process. Participants were required to check that they had read the informed consent information and agree to participate in the study before being directed to the survey. In order to detect careless responding, validity check items were included with the online survey. Additionally, duplicate IP addresses were blocked from use using Qualtrics to prevent duplicated responses and multiple survey attempts.

Participants had the potential to experience psychological stress while participating in this study due to the complex and sensitive nature of suicidality; therefore, contact information for national mental health agencies and crisis hotlines was provided in both the recruitment email and consent form. Participants were not guaranteed to receive benefits for this study, though participants did have the opportunity to enter into a lottery and be randomly selected to win one of ten \$10 gift cards to Amazon. Those chosen received these gift cards via email upon completion of data collection.

Measures

The Perceived Spiritual Support Scale-Revised (PSSS-R; Ai et al, (2005). The PSSS-R is a 12-item a global and holistic measure of participants' level of spirituality and perceived spiritual support (Ai et al., 2020, 2021). The scale assesses the use of

spirituality as a resource among individuals with diverse identities and belief systems (Ai et al., 2020, 2021). The questions (e.g., “I have an inner resource from my spiritual relationship with God, or other spiritual/sacred source, that helped me face difficulties”) are in a 4-point Likert scale format, with higher scores indicating a greater sense of perceived spiritual support (Ai et al., 2021, 514). Total scores may range from 12-48 and are calculated by summing responses from all 12 questions (Ai et al., 2020). The model explores four primary factors related to perceived spiritual support including emotional support, spiritual resources, intimacy and cognitive guidance; the total score from the PSSS-R will be utilized in this study (Ai et al., 2020, 2021).

The psychometric properties of the PSSS were determined over the course of three studies, following the attacks that occurred on September 11, 2001, with individuals from the U.S. population belonging to a wide range of diverse belief systems and sociocultural identities. The groups sampled consisted of undergraduate and graduate students, in addition to middle-aged and older individuals, representing different ages, races, ethnicities, religions, and educational backgrounds (Ai et al., 2005, 2021). The sample was made up of individuals ranging in age from 18-89 and in two of the three studies, the proportion of females to males was 3:1. Additionally, the first two studies’ participants were majority White, though in the final study, more than 60% identified as Black (Ai et al., 2005, 2021). Finally, Christianity was the most commonly identified religion, making up over half of the sample in all three studies (Ai et al., 2005).

Across the three studies, this scale’s reliability was calculated to be between 0.97-0.98 each time; this provides strong support for the instrument’s reliability (Ai et al., 2005, 2021). Reliability was also demonstrated through satisfactory split-half results,

with $r_s=0.95$ (Ai et al., 2005). The instrument's validity was supported through comparison of mean scores (no difference between males and females or differences in age), and use of principal axis factoring, which revealed items all loading onto a single factor (Ai et al., 2005). Confirmatory factor analysis revealed the unidimensional model accounted for over 35% of the observed variance (Ai et al., 2005, 2021). Finally, multivariate analyses were used to demonstrate the scale's strong validity in predicting outcomes; individuals with greater senses of perceived spiritual support were better able to manage crisis and distressing life situations (Ai et al., 2005, 2021). Further support for the instrument's reliability and validity has been demonstrated since this initial study (Ai et al., 2011, 2020, 2021). The original scale's language was revised to promote inclusivity, particularly among indigenous groups and those who practice non-mainstream religions; therefore, the revised scale was utilized for this study (Ai et al., 2021).

Counselor Suicide Assessment Efficacy Survey (CSAES; Douglas & Morris' (2015). This instrument was used to measure participants' self-efficacy related to suicide risk assessment and intervention. The CSAES' development is grounded in evidenced-based scale construction literature and the code of ethics set forth by the American Counseling Association (ACA) (Douglas & Morris, 2015). The survey is a 25-item questionnaire utilizing Likert scale responses ranging from 1 (not confident) to 5 (highly confident). The total possible score on the CSAES is 125, with higher scores indicating a greater level of counselor self-efficacy related to suicide assessment and intervention (Douglas & Morris, 2015). The CSAES can be used as a whole or by subscale depending on a study's research purpose; for this study, the survey as a whole was used (Douglas &

Morris, 2015). This latent construct model consists of four factors that can be compared by dividing the mean score for each subscale by the number of items; these consist of general suicide assessment (#s 1-7), personal characteristics (#s 8-17), suicide history (#s 18-20), and suicide intervention (#s 21-25). Since overall self-efficacy in suicide risk assessment is being analyzed, only total scores out of 125 were examined.

While originally developed for school counselors, the scale was normed on 324 individuals ranging from graduate students currently enrolled in counseling courses to licensed psychologists, with the majority of respondents identifying as master's-level students (Douglas & Morris, 2015). The scale has demonstrated strong structural aspects of validity and was able to detect varying levels of counselor self-efficacy in conducting suicide risk assessment (Douglas & Morris, 2015). The scale's reliability overall and among subscales was also high, with all Cronbach's alpha values exceeding 0.88 (Douglas & Morris, 2015). Further research has demonstrated the scale's reliability and internal consistency (Simmons, 2021). This scale is highly beneficial in assessing counselor self-efficacy in conducting suicide risk assessment from a theory- and research-informed approach (Douglas & Morris, 2015; Gallo, 2016). One notable limitation of the study validating this instrument is that collected demographic data was not particularly detailed and significantly more females were surveyed than males (258:61), making it difficult to speak to this assessment's validity with diverse populations of clinicians (Douglas & Morris, 2015; Simmons, 2021).

Questionnaire on Attitudes Towards Suicide (ATTS; Renberg & Jacobsson, (2003). In order to measure participants' attitudes toward suicide, the Renberg and Jacobsson (2003) Questionnaire on Attitudes Towards Suicide (ATTS) was utilized. The

scale was originally developed in 1986, and then updated in 1996 through use of postal surveys in the Swedish general population (Renberg & Jacobsson, 2003). For this study, the updated 37-item version of the scale was used. Questions are on a 5-point Likert scale, ranging from 1=totally disagree to 5=totally agree (Norheim et al., 2016; Renberg & Jacobsson, 2003). This proposed 4-factor model was used for this study due to its normalization process being performed on mental health clinicians. These four factors include (a) avoidance of communication, (b) suicide as acceptable, (c) suicide as common, and (d) suicide as preventable (Norheim et al., 2016). The moderating effects of each of these four attitude subscales were examined.

The 1996 version of the ATTS demonstrated a 10-factor model to explain attitudes toward suicide; while this updated model provided higher internal consistency, this value was still considered low (Renberg & Jacobsson, 2003). Strong construct validity was shown through obtaining a 10-factor model in both the original and updated versions of the scale (Renberg & Jacobsson, 2003).

The ATTS was recently used to assess attitudes towards suicide In outpatient clinicians and mental health providers working in Russia and Norway (Norheim et al., 2016). The diverse participant pool consisted of individuals from different counseling professions, of different ages, and of different religious and spiritual backgrounds; though the majority of participants were once again female (Norheim et al., 2016). Factor analysis for this study originally aligned with the 1996 study's suggested 10-factor model; however, upon further evaluation of factor loadings, a four-factor structure was found to be a better overall fit for the data (Norheim et al., 2016; Renberg & Jacobsson, 2003). Although the explained variance was reduced from 61% to 41%, the overall

stability of the model increased with the reduction in number of subscales (Norheim et al., 2016).

The scale's reliability and validity has been further tested and supported by recent research (Ghasemi et al., 2015; Kim & Park, 2014; Norheim et al., 2013, 2016). Though Norheim et al. (2016) used the original scale in their study, it is necessary to note the scale's limited use thus far with populations in the United States. The ATTS was chosen for this study due to its application with diverse populations and its ability to measure a broad range of attitudinal dimensions related to suicide (Norheim et al., 2013, 2016). It is also important to comment on the language used in this scale; the ATTS items use the phrase commit suicide as opposed to death or dying by suicide, which is the current accepted phrase in the field of counseling. It will be necessary to consider how this language may have impacted study results and participant responses.

Power Analysis

The power and effect size needed when using multiple regression to assess moderating effects was assessed via a review of moderating effects with continuous variables and G*Power 3.1 (Bodner, 2017). Based on the effect size threshold identified in Bodner (2017), to reach a medium effect size of 0.15, a sample size of 114-132 is needed to achieve a power level of 0.80 and an alpha level of 0.05 with five total predictors (the total score on the PSSS-R and the four ATTS subscale scores).

Data Analysis

Once data collection was complete, responses were assessed for missing data. Following the standards set forth by Schlomer, Bauman, and Card (2010), the proportion and patterns of missing data are reported in this study's findings. Missing data were

divided into the following three categories of patterns: missing completely at random (MCAR), missing at random (MAR), and not missing at random (NMAR) (Schlomer et al., 2010).

In order to differentiate between MCAR data and MAR data, I created a dummy variable and used omnibus statistical testing in SPSS 26.0 to examine if they are related to any of the variables in the model (Little, 1988; Schlomer, Bauman, & Card, 2010). NMAR data can be challenging to distinguish due to lack of available empirical testing options and require significant conceptual consideration; for this study, I used theory and existing literature to consider possible reasons for NMAR data (e.g., choice of language used in the survey, methods of recruitment, or individuals who do not identify as spiritual choosing not to participate because of the study's focus) (Schlomer et al., 2010). Multiple imputation was then used to impute missing data as this method was demonstrated to provide regression coefficients with less bias than other imputation methods and allow for maximum use of reported data (Schlomer et al., 2010).

A complete test of assumptions as described in Mendenhall and Sincich (2012) was also performed using SPSS 26.0 to ensure an accurate model and assess multicollinearity. The Kolmogorov-Smirnov and Shapiro-Wilk tests were used to assess for univariate and multivariate normality, though it is important to note the Shapiro-Wilk is most reliable with sample sizes smaller than fifty (Mendenhall & Sincich, 2012). To further assess multicollinearity, Eigenvalues and condition indices were calculated in SPSS 26.0. Power of the final model was determined using G*Power 3.1.

After accounting for missing data and assessing collinearity, quantitative correlational and multiple logistic regression analyses were used to understand the

relationship between the variables of interest. Moderated multiple regression analysis using SPSS 26.0 was used to see if self-reported levels of perceived spiritual support predict counselor self-efficacy in conducting risk assessment and to assess if attitudes about suicide moderate the relationship between perceived spiritual support and self-efficacy (Aguinis et al., 2005). In order to test for moderation effect, both predictors were mean centered before the centered predictor (perceived spiritual support scores) was multiplied by the moderating predictor variable (attitude toward suicide); the two mean centered predictors and the calculated interaction predictor variable were then assessed using the multiple logistic regression analysis function in SPSS 26.0. This was repeated for all four subscale levels of the predicted moderating variable. These regressions utilized the SPSS PROCESS macro-Version 3.4 as described in Hayes (2018) in order to better visualize the moderating effects of the predictor variables. Finally, the Johnson-Neyman technique was used to assess significance of the observed moderative effects (Hayes, 2018).

Chapter Three: Results

This chapter reports the study's management of missing data and findings from the statistical analyses performed.

Preparation of Data

After agreeing to participate, validity check items were required to be answered correctly (to ensure understanding) before individuals could move on to the rest of the survey; participants who answered any of these items incorrectly were provided information regarding the study (e.g., risks, benefits, voluntary participation, etc.) and prompted to re-answer the question; this helped to provide a more thorough informed consent and prevent careless responding. Demographic questionnaire responses were used to help determine if participants met criteria for participation. Three responses were deleted due to participants identifying as licensed psychologists as the focus of this study is Master's level clinicians. Since survey questions were administratively "required" to be answered within Qualtrics before participants could continue to the next item, no missing data resulted from the process of survey administration. Data management and preparation resulted in a total of 132 participants being included in this study.

Assumptions of Regression Analysis

After addressing missing data and mean-centering the independent variable and four moderators, data were analyzed to ensure assumptions had been met for Moderated Multiple Regression (MMR). First, the relationship between the dependent variable (self-

efficacy scores) and the independent variables must be linear. As depicted in Figure 2, the residuals appear to be in a band centered around zero, with no tendencies in the plot; thus, this assumption has been met. This residual pattern also suggests there is no concern with heterogeneity of variance. Figure 3 indicates the error term has a mean of $5.66e^{-16}$, which is nearly 0. Additionally, the distribution of the residuals is approximately normal, as demonstrated by the straight line shown in Figure 4. Given this data, assumptions for MMR appear to have been adequately met and supports and adequate model.

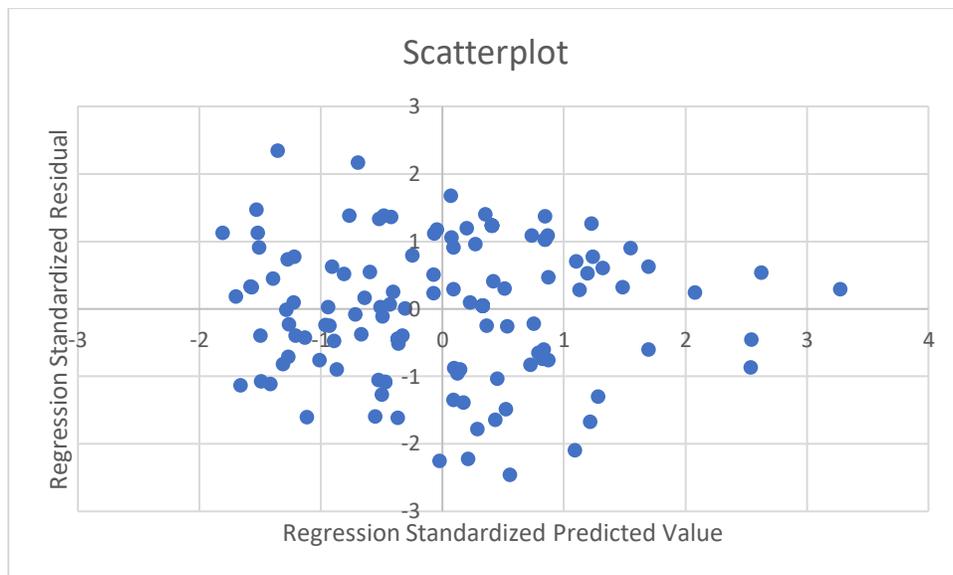


Figure 2. Plot of residuals versus \hat{y}

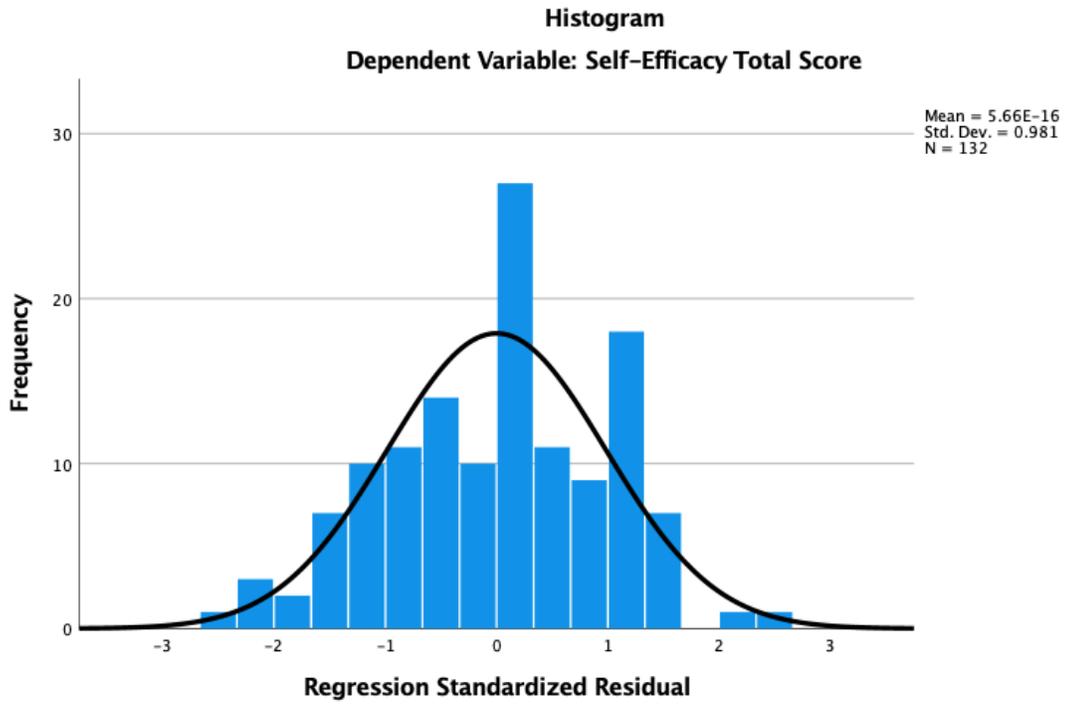


Figure 3. Mean of residuals

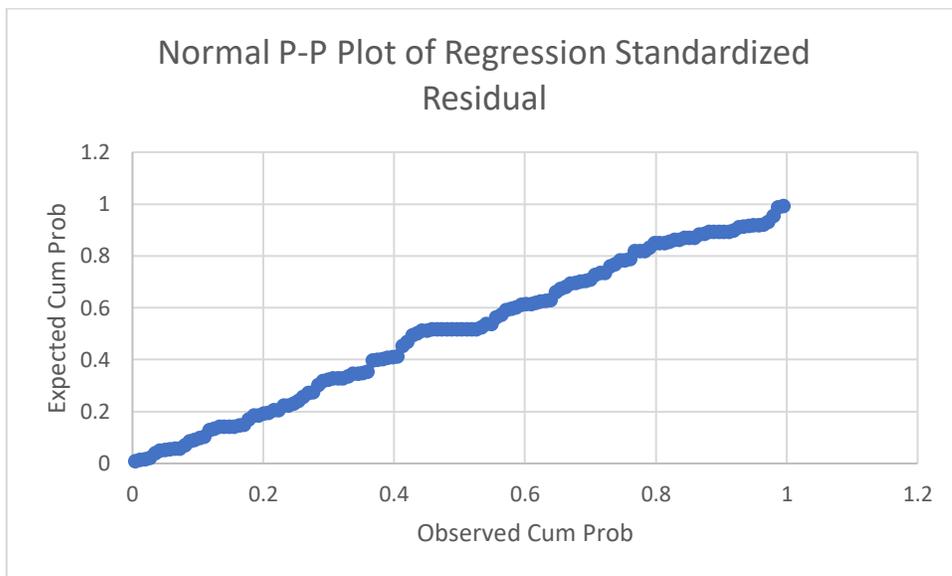


Figure 4. Distribution of residuals

Data was assessed for outliers using Mahalanobis distance; the result of 4.962 suggests it is unlikely there are potential outliers in the data that must be addressed. Given the Cook Distance of .011 is less than one, influential observations are not having any effect on the independent variables. Multicollinearity diagnostics were then run on the data (results shown in Table 3). The values shown in the condition index fall well below the threshold of 15 that suggests multicollinearity. There also do not appear to be any Eigenvalues close to zero; these results further suggest there is not a concern of multicollinearity. Final power was calculated to be 0.852.

Table 3. *Multicollinearity Diagnostics*

Dimension	Eigenvalue	Condition	PSS	Avoidance	Acceptable	Common	Preventable
		Index					
1	1.795	1.000	.01	.08	.11	.12	.10
2	1.357	1.150	.31	.15	.06	.04	.01
3	1.000	1.340	.00	.00	.00	.00	.00
4	.809	1.490	.01	.00	.07	.12	.84
5	.641	1.673	.22	.78	.01	.20	.04
6	.398	2.124	.45	.00	.75	.52	.01

Estimates for internal consistency were calculated for the measures utilized in this study to demonstrate reduced possibility that error occurred within variable measurement (Hayes, 2018; Memon et al., 2019). Using Cronbach's alphas, scores between 0.50 to 0.70 are considered to demonstrate moderate reliability, while scores of 0.75 and above suggest high reliability (Hayes, 2018; Zinke et al., 2010). Statistical analyses showed that three variables fell into the moderately reliable category (suicide is common, $\alpha=0.52$; suicide is acceptable, $\alpha=0.68$; avoidance of communication, $\alpha=0.67$), while the remaining two had Cronbach's alphas greater than 0.75, indicating minimal error

(perceived spiritual support, $\alpha=0.77$; and preventable attitudes, $\alpha=0.76$). Additionally, no significant differences in self-efficacy scores were observed between participants that completed risk assessment as part of their graduate training compared to those that had to seek outside training. Furthermore, there were no significance differences in self-efficacy scores when comparing participants whose graduate program was accredited by CACREP versus those that were not.

Hypothesis 1

Moderated multiple regression analysis using SPSS 26.0 was used to see if self-reported levels of perceived spiritual support predict counselor self-efficacy in conducting risk assessment and to assess if attitudes about suicide moderate the relationship between spirituality and self-efficacy. First, in assessing Perceived Spiritual Support's ability to predict counselor self-efficacy in conducting risk assessment, data analyses reveal an R^2 value of .050. This indicates how much of the total variation in the dependent variable can be explained by the independent variables in this case (i.e., 5%). Additionally, the model is strong ($F=6.818$; $p=.01$). The t-test values are statistically significant at the ($p<.05$) level, meaning that the regression coefficients are significantly different from zero. These are all indicators that the fit of the model is adequate and significant. Thus, analyses support the first hypothesis presented in this study. So, 5% of the total variance in counselor self-efficacy in conducting risk assessment is explained by perceived spiritual support. When we adjust for the complexity of the model, our R^2 value=.043, suggesting 4.3% of the total variation in self-efficacy scores can be explained by perceived spiritual support.

Hypotheses 2-5

To test the remaining study hypotheses, possible interaction effects on counselor self-efficacy were calculated between perceived spiritual support and each of the four moderating attitude variables. **Hypothesis 2** was used to assess the moderating effect of having attitudes toward suicide based on the avoidance of communication on the predictive relationship between perceived spiritual support and counselor self-efficacy in conducting risk assessment leading to decreased self-efficacy scores. The interaction effect was statistically significant with a significant change in $F(12.964)$ at $p=.001$ (see Table 3). Moreover, further analysis of the “avoidance of communication” moderator indicated a negative predictive relationship. Thus, the predictive relationship between perceived spiritual support and counselor self-efficacy in conducting suicide risk assessment was significantly weakened when clinicians endorsed believing people often avoid discussing the topic of suicide.

Hypothesis 3 examined the possible moderating effect attitudes that suicide is acceptable will have on the relationship between perceived spiritual support and counselor self-efficacy in conducting risk assessment. Moderation analyses did not yield significant results for this interaction effect (F change=1.57, $p=.213$); therefore, the hypothesis that this attitude would strengthen then relationship between the predictor variable (perceived spiritual support) and counselor self-efficacy scores was not supported.

Hypothesis 4 tested if attitudes that suicide is common strengthened the relationship between perceived spiritual support and counselor self-efficacy in conducting risk

assessment, increasing self-efficacy scores. Results were not statistically significant (F change=0.07, p=.798); thus, Hypothesis 4 was not supported.

Hypothesis 5 assessed the moderating effect of preventable attitudes toward suicide on the positive, predictive relationship between perceived spiritual support and counselor self-efficacy in conducting risk assessment. Specifically, existing literature suggests strong attitudes of preventability would likely strengthen the relationship between perceived spiritual support, resulting in increased counselor self-efficacy scores. Moderation analyses did not yield significant results (F change=0.86, p=.522); therefore, this final hypothesis was also not supported in this study. See Table 4 for further details on moderation analyses.

Table 4. *Moderation Analyses of Interaction Effects*

Attitude Subscale	R²	Adjusted R²	F Change	Significance
Preventability	.117	.096	.860	P=.522
Accepting	.071	.050	1.566	P=.213
Common	.050	.028	.066	P=.798
Avoidance of Communication	.184	.164	12.964	P=.001

To better visualize the moderating effect of having attitudes toward suicide based on the avoidance of communication on the predictive relationship between perceived spiritual support and counselor self-efficacy in conducting risk assessment leading to decreased self-efficacy scores, a simple slopes plot was created (see **Figure 5**). Scores on the avoidance of communication subscale were split into two groups based on means: 1) Low Scores and 2) High Scores. The decrease in positive slopes (0.52 to 0.34) as scores on the avoidance subscale increased demonstrates that the predictive relationship between perceived spiritual support and counselor self-efficacy in conducting suicide risk

assessment was significantly weakened when clinicians endorsed believing people often avoid discussing the topic of suicide.

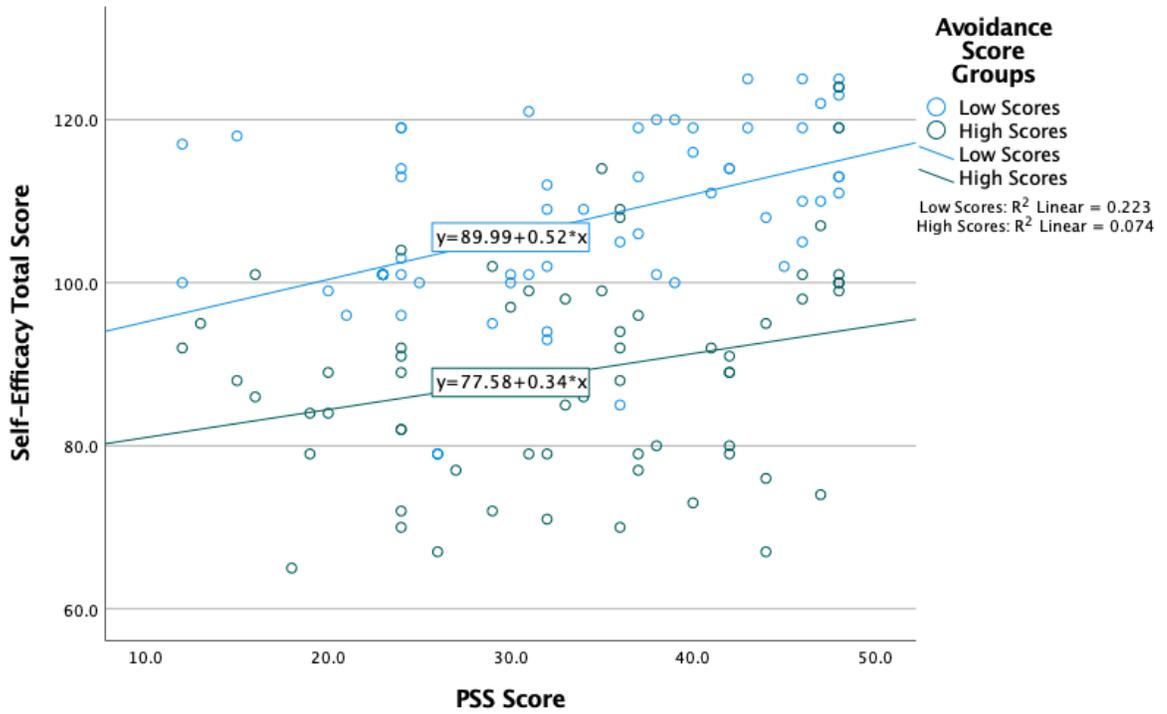


Figure 5. Plot of moderation simple slopes

Chapter Four: Discussion

This chapter reviews the key findings from our study, assesses study limitations, and integrates our results to existing theory and research to determine future implications for curriculum, research, and practice. The present study was conducted to assess the relationship between perceived spiritual support and counselor self-efficacy in conducting suicide risk assessment, and the moderating effects of attitudes about suicide on this relationship.

Empirical Exploration of Research Hypotheses

Based on current theory, research, and literature, the present study explored factors that have the potential to impact therapists' self-efficacy when assessing patients for presence of suicidality and level of overall risk (Gallo, 2018; Norheim et al., 2013, 2016). Statistical analyses provided strong support for Hypothesis 1. Self-reported clinician levels of perceived spiritual support have a positive, predictive relationship with self-efficacy in performing thorough risk assessment. As levels of perceived spiritual support increase, so do self-reported levels of counselor self-efficacy in risk assessment practices. This finding aligns with theory and previous research demonstrating the protective effects of spirituality and resulting feelings of support and acceptance (Matthews, 2004; Pollock, 2007). Additionally, our results further emphasize the impact different personal and professional variables may have on therapists' confidence in their skills (Aherne et al., 2018; Douglas & Morris, 2015; Gallo, 2018).

Our results also demonstrated that as stated in Hypothesis 2, participants who endorsed stronger attitudes that suicide is a topic people often avoid talking about had lower self-efficacy scores than other participants with the same perceived spiritual support scores who did not endorse these attitudes. Despite being unsubstantiated for both at-risk groups and the general population, many mental health professionals believe that talking about suicide may lead to or exacerbate suicidality (Dazzi et al., 2014). Therapists that endorse the notion that suicide should not be/is not discussed risk missing imperative details that could reveal a client's overall level of acuity and internal functioning (Dazzi et al., 2014; Norheim et al., 2013). Therefore, one may conclude that if clinicians are not performing comprehensive, evidence-based suicide risk assessment interventions with their patients, their self-efficacy in these skills would be weakened (Bandura, 1982, 1994; Gallo, 2016).

Hypothesis 3 was not statistically supported. In other words, attitudes that suicide can be acceptable or understandable under certain circumstances did not significantly change the strength or direction of the relationship between perceived spiritual support and counselor self-efficacy in conducting risk assessment. Based on existing theory, it was hypothesized that clinicians who hold more empathetic and accepting attitudes toward suicide would experience higher levels of self-efficacy in conducting risk assessment (Gagnon & Hasking, 2012). However, it may be that clinicians feel empathetic, yet have a stronger desire to prevent suicide than accept it (Werth & Liddle, 1994). While many study participants (approximately 58%) responded they could understand considering suicide if diagnosed with a life-threatening, incurable condition, participants overall did not endorse 'accepting' attitudes toward suicide; over 53% of

participants' average scores for this category fell into the 'Disagree' or 'Totally Disagree' classification.

Theory and empirical research provide strong support for the Zero Suicide model, which inherently aims to prevent all suicides regardless of circumstances (Brodsky et al., 2018). Given this approach is considered the gold standard of suicide risk assessment and used by many clinicians, it may be that simply labeling attitudes as accepting (despite being based in empathy) does not adequately represent the complexity of this attitude construct (Brodsky et al., 2018). Further support for this possible explanation can be seen in the measurements for internal reliability. This construct demonstrated only moderate reliability, which while adequate for the purpose of this study, may suggest further tailoring of this scale is needed when assessing clinicians specifically. The Limitations section of this chapter will examine this in greater depth.

Hypothesis 4 was not supported. In other words, clinician attitudes that suicide is common did not significantly change the strength or direction of the relationship between perceived spiritual support and counselor self-efficacy in conducting risk assessment. Given the notion that suicidality is a common experience is endorsed not only by clinicians, but also the CDC, it was hypothesized that if clinicians see suicide as common and recognize the frequency in which suicidality occurs in the U.S., this has the potential to help therapists recognize the need to be trained in adequately assessing suicide risk (Aherne et al., 2018; Centers for Disease Control and Prevention, 2021; Cramer et al., 2013). It was also thought this attitude may encourage providers to more frequently assess for suicide risk and display less judgement when conducting risk assessment (Aherne et al., 2018; Cramer et al., 2013). Since no association was found during data

analysis, existing literature suggests a possible explanation may be that overall, clinicians believe suicide is common due to the alarming rates seen in the United States, and this commonality does not affect the relationship between perceived spiritual support and self-efficacy (Centers for Disease Control and Prevention, 2023). Theory also suggests that these results may reflect mixed feelings among counselors about how to respond to this level of commonality. While some may be called to action (as hypothesized), others may be overwhelmed by the responsibility of risk assessment, which can negatively impact their self-efficacy (Bandura, 1994; Cramer et al., 2013; Dubue & Hanson, 2020). Ambivalence within this attitude construct could help to explain the achieved results.

Finally, Hypothesis 5 was not statistically supported during the analysis of interaction effects. Meaning, clinicians' preventable attitudes toward suicide did not significantly moderate the direction or strength of the relationship between perceived spiritual support and counselor self-efficacy in conducting risk assessment. Results from this study indicate that the vast majority of therapists believe that suicide is preventable, with over 89% of participants having average scores in this category in the 'Agree' and 'Totally Agree' categories; this aligns with the limited existing research on clinicians' in the United States attitudes toward suicide (Douglas & Morris, 2015; Werth & Liddle, 1994). With this attitude being so widely shared among mental health professionals, it may be that this particular attitude construct has a less significant impact on clinician outcomes (as it can almost be considered inherent among practitioners).

Limitations

While this study is novel, it has some limitations that are worth noting. First, the snowball sampling methods utilized during data collection could have influenced results in this study. This non-random style of participant recruitment led to an overrepresentation of counselors practicing in the Western part of the United States (69.9%); due to this writer being located in Colorado, it is likely the survey did not reach clinicians in all states equally given the influence initial study participants have on the next possible set of participants when utilizing snowball sampling (Browne, 2005). A greater number of counseling sites and training programs in Colorado were contacted than other states due to this writer's existing professional network. This may have biased results (which limits their generalizability) considering research shows adults in Colorado tend to identify more as spiritual than religious, and of those that are religious, only 64% identify as Christian, compared to states like Alabama where 86% of religious individuals identify as Christian (Lipka & Gecewicz, 2017; Pew Research Center, 2014).

Other concerns with generalizability arise when we look further into the descriptive statistics. Over 65% of participants identified as White, possibly limiting the applicability of these results to BIPOC and other non-White clinicians. This is hypothesized because research also utilizing the ATTS scale shows differences in attitudes toward suicide among distinct racial and ethnic groups (Wright, 2012). For example, qualitative data from existing literature suggest avoidance of communication is a more severe issue in communities of color due to inequitable reporting in the media, leading many individuals to lack clear understanding of the significant impact suicide has on different racial/ethnic groups (Wright, 2012); higher scores on this attitude subscale

could have provided more robust support for Hypothesis 2, while differences in scores on the other three attitude subscales may have impacted their significance as moderators (Aguinis et al., 2005; Bodner, 2017; Wright, 2012).

Additionally, over 81% of participants identified as women, which does not adequately represent the population of trans, non-binary, gender fluid, and male clinicians currently working the field (Stone, 2023). Similar to the issue created by having a lack of diverse racial and ethnic representation among participants, recent empirical research demonstrates significant gender differences in attitudes toward suicide (Poreddi et al., 2016). Existing literature shows men (did not specify cisgender/transgender identity) tend to more strongly endorse the avoidance of communication, preventability, and acceptability attitudes toward suicide compared to women (Poreddi et al., 2016). It is possible that a more inclusive participant pool could have led to differences in attitude subscale scores, thus impacting the significance of regression and moderation results (Aguinis et al., 2005; Bodner, 2017). However, in-line with existing research in the U.S., significantly more participants identified as spiritual (76.7%) as opposed to religious (33%) (Lipka & Gecewicz, 2017). Therefore, further research with more diverse populations of clinicians could help provide increased insight into the presenting research questions given the between-group differences seen among attitudes toward suicide (Poreddi et al., 2016; Wright, 2012).

The second limitation to note involves the inclusion and exclusion criteria in this study. To avoid concerns with reliability and between-group differences impacting study results, doctoral-level psychologists were excluded from this study. While this decision helped support the study's reliability, it limits the generalizability of these results to

Master's level clinicians only. Doctoral level psychologists also have a high frequency of treating suicidal patients over the course of their careers, and it would be important to apply these same research questions to this population to inform future risk assessment training, research, and graduate curriculum (Dubue & Hanson, 2020). Readers should avoid overgeneralizing results of this study to populations who were not represented, such as psychologists and other specializations such as school counseling.

Third, three of the variable measures (i.e., suicide is common, suicide is acceptable, and avoidance of communication) produced Cronbach's alpha scores falling in the moderately reliable range (Hayes, 2018). Issues may have arisen due to problems with cross-cultural validity (Hayes, 2018; Memon et al., 2019). All three of these variables came from the ATTS portion of the survey; as previously stated in this report, despite this measure's strong reliability and validity in previous studies, it has been used scarcely in studies assessing clinicians in the United States (Norheim et al., 2013, 2016).

Additionally, this measure was chosen specifically for this study due to its previous success with diverse populations and its ability to measure multiple attitudinal dimensions related to suicide (Norheim et al., 2013, 2016); however, it is important to note some phrases used within this measure, such as 'commit suicide', are considered outdated and even harmful within the counseling profession (Olson, 2018). Current researchers and clinical counselors have moved to using phrases such as death or dying by suicide, as this reduces feelings of stigma and judgement surrounding an already difficult topic (Olson, 2018). Therefore, it is necessary to consider the impact language and cross-cultural validity may have had on the effectiveness of this measure and provides support for re-evaluation (possibly through factor analysis); while Cronbach's

alpha scores all at least fell in the moderately reliable range, further information could be gained from using measures that all score in the high reliability range (Memon et al., 2019).

Implications

The present study demonstrated strong evidence for the relationships between perceived spiritual support, attitudes toward suicide, and counselor self-efficacy in conducting suicide risk assessment. This study is novel in three important ways: (a) it is both the first to explore the direct relationship between perceived spiritual support and counselor self-efficacy in providing risk assessment and the first to test the impact of attitudes toward suicide on this relationship, (b) it used quantitative MMR to assess salient constructs within the complex dimension of attitudes towards suicide among clinicians, and (c) it helps begin to show how attitudes toward suicide related to avoidance of communication can negatively impact a counselor's self-efficacy in performing arguably one of the most important set of skills within the profession (Cramer et al., 2017; Gallo, 2016, 2018).

The moderating effect of clinicians reportedly believing that people often avoid discussing the topic of suicide (i.e., avoidance of communication) on the relationship between perceived spiritual support and counselor self-efficacy in conducting suicide risk assessment has particularly crucial implications for future clinical practice and training. As stated, many counseling programs in the U.S. do not comprehensively include suicide risk assessment in their graduate training (Dastagir, 2020). This issue can lead providers to feel unprepared and downright terrified when the subject of suicide is brought up in session, leading them to avoid the topic altogether (Dastagir, 2020; Elliott et al., 2018).

When individuals who are struggling with suicidal thoughts seek counseling, they expect to be treated by someone who is prepared to address the concern and provide adequate intervention; clinicians also hold an ethical obligation to practice within their scopes of expertise (American Counseling Association, 2014; Dastagir, 2020).

Avoiding communication with clients about suicide could result in a clinician being unaware of a patient's suicidality until they are in crisis; in this case, many unexperienced clinicians may jump to hospitalizing clients without the completion of adequate suicide risk assessment and intervention (Cramer et al., 2013; Dastagir, 2020; Dubue & Hanson, 2020). Thus, clients are not only experiencing increased distress from being in crisis, but then further traumatized by the experience of being placed on a psychiatric hold (Dastagir, 2020; Sareen et al., 2022). In these scenarios, clinicians may also be jeopardizing client autonomy and neglecting the importance of collaborative relationships on positive psychological outcomes (American Counseling Association, 2014; Sareen et al., 2022). Therefore, data from this study represent a call to action to not only increase the frequency in which comprehensive suicide risk assessment is covered in graduate training programs, but also address competence, self-efficacy in conducting suicide risk assessment, and the great importance of asking clients about suicide with graduate students.

It is important for future research to work on improving the reliability and validity of instruments used to measure attitudes toward suicide among clinicians in the United States. For example, the language utilized in the ATTS could be updated to better reflect terms used in current clinical practice (Olson, 2018). Researchers could also consider running a confirmatory factor analysis on the ATTS to determine how adequately the

items used with U.S. clinicians represent the four attitude constructs; more specifically, this could help to reveal which of the items may be causing concerns. Furthermore, if items are removed as result of the confirmatory factor analysis, it may also be beneficial to run an exploratory factor analysis to inform the revision of this instrument.

Results from this study also suggest counseling instructors should thoughtfully explore how the four major sources of self-efficacy can be used to develop confidence in one's suicide risk assessment skills and abilities (Bandura, 1982, 1994). In addition to self-efficacy, impacts of open and non-judgmental communication regarding suicide should be reviewed. Clinicians who believe that suicide should not be discussed risk missing crucial details that may speak to a client's current functioning and overall level of acuity (Dazzi et al., 2014; Norheim et al., 2013). Failing to gather this important information can hinder the provision of competent, thorough risk assessment and neglects client safety (Cramer et al., 2013; Dubue & Hanson, 2020; Martinengo et al., 2019). Therefore, instructors should also strongly emphasize reflecting on explicit and implicit personal biases regarding spirituality and attitudes toward suicide (FitzGerald & Hurst, 2017).

Furthermore, future studies could explore other clinician outcomes related to perceived spiritual support (e.g., increased self-efficacy with other specific counseling skillsets). This is a relatively new concept in the field of counseling psychology and shows promising initial connections to adaptive therapist response such as increased self-efficacy (Ai et al., 2020; Pollock, 2007). There is extensive research on how positive religious and spiritual coping, of which positive spiritual support is a part, is correlated with positive outcomes. Conversely, negative religious and spiritual coping, which could

include interpersonal religious struggles limiting spiritual support, makes it harder to cope with the stress (Abu-Raiya & Pargament, 2015; Ano & Vasconcelles, 2005; Pargament et al., 1998). Extending upon this recommendation, other possible theoretically based moderators, such as counseling setting, should be explored. This may help to better understand the relationship between perceived spiritual support and counselor self-efficacy in suicide risk assessment (Elliott et al., 2018).

Finally, utilization of different research designs could help expand our understanding of the posed research questions. For instance, using a mixed methods approach could help provide rich information that not only helps answer the hypotheses, but also provides interpretive insight if hypotheses are not found to be statistically significant. A longitudinal design could provide information about self-efficacy in conducting suicide risk assessment develops over time among clinicians. An experimental research design may have the ability to implicate causality between the predictor and dependent variable in this study. Researchers could also consider replicating this study with different populations such as doctoral-level psychologists or with Master's level clinicians located in different geographic regions nationally or internationally.

Practicing clinicians should work to address personal biases that could impact their ability to provide quality, sound care to their patients (Elliott et al., 2018). This includes how one's attitudes toward presenting concerns such as suicidality impact clinicians' ability to provide comprehensive, culturally-responsive risk assessment (Brodsky et al., 2018; Cramer et al., 2017). This feedback is based on this study's finding that avoidance of communication attitudes moderated the relationship between perceived spiritual support and counselor self-efficacy in conducting risk assessment, leading to

decreased self-efficacy scores. Moreover, given the positive implications for therapists with high levels of perceived spiritual support, results from this study suggest this topic of discussion should not be avoided in therapy, regardless of a therapists' personal religious or spiritual attitudes (Hall, 2017; La Guardia et al., 2019).

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APPENDICES

Appendix A: Counselor Suicide Assessment Efficacy Survey

Below are listed risks, warning signs, and potential situations a counselor may face when conducting a suicide risk assessment or implementing an intervention. Please read and respond to each statement by circling the number that most closely corresponds with your level of confidence, using the following scale:

1= Not Confident

2= Slightly Confident

3= Moderately Confident

4 = Generally Confident

5 = Highly Confident

1. I can effectively inquire if a client has had thoughts of killing oneself.
2. I can effectively assess hopelessness.
3. I can effectively assess whether a client has means to carry out a suicide plan.
4. I can effectively inquire whether a client has a suicide plan.
5. I can effectively counsel a client who has had a history of making suicidal threats, but has had no attempts.
6. I can effectively counsel a client who has previously attempted suicide.
7. I am able to assess a client's level of risk for a suicide attempt.
8. I can help prevent a suicide attempt.
9. I can effectively ask a client about their drug or alcohol abuse.
10. I can effectively ask a client about their history of sexual abuse.
11. I can effectively ask a client about their history of mental illness.
12. I can effectively ask a client questions to assess whether they have low self-esteem.
13. I can effectively inquire whether a client has withdrawn from relationships.
14. I can effectively assess a client's acceptance of sexuality.
15. I can effectively talk with a client about their hygiene.
16. I can effectively discuss with a client their writings about death.
17. I can appropriately inquire whether a client has been a victim of abuse.
18. I can effectively ask a client about their previous suicide attempts.
19. I can effectively ask a client about their personal history of self-harming behavior.
20. I can effectively ask a client about their family history of suicide.
21. I know the point at which I need to break confidentiality.
22. I am able to appropriately intervene if a client reports suicidal thoughts, but I do not believe them.
23. I am able to intervene appropriately if a client denies suicidal thoughts, but I do not believe them.
24. I can appropriately take action if I determine a client is moderately at risk for suicide.
25. I can appropriately intervene if a client is at imminent risk for suicide.

Scoring: The total possible score on the CSAES is 125, with higher scores indicating a higher level of self-efficacy related to suicide assessment and intervention. CSAES can be scored as a whole or by subscale depending on research purpose. In order to compare levels of self-efficacy between scales, divide the mean score for each scale by the number of items.

Subscales:

- General Suicide Assessment consists of 7 items (#s 1-7) for a maximum score of 35.
- Assessment of Personal Characteristics has 10 items (#s 8-17) for a maximum score of 50.
- Assessment of Suicide History has 3 items (#s 18-20) for a maximum score of 15.
- Suicide Intervention has 5 items (#s 21-25) for a maximum score of 25.

Appendix B: Questionnaire on Attitudes Towards Suicide

The following survey is used to measure attitudes toward suicide. Please read and respond to each statement by circling the number that most closely corresponds with your level of agreeance, using the following scale:

1= Totally disagree, 2= Disagree, 3= Not sure, 4 = Agree, 5 = Totally agree

1. It is always possible to help a person with suicidal thoughts.
2. Suicide can never be justified.
3. Committing suicide is among the worst thing to do to one's relatives.
4. Most suicide attempts are impulsive actions.
5. Suicide is an acceptable means to terminate an incurable disease.
6. Once a person has made up their mind about committing suicide, no one can stop them.
7. Many suicide attempts are made because of revenge or to punish someone else.
8. People who commit suicide are usually mentally ill.
9. It is a human duty to try to stop someone from committing suicide.
10. When a person commits suicide, it is something that they have considered for a long time.
11. There is a risk of evoking suicidal thoughts in a person's mind if you ask about it.
12. People who make suicidal threats seldom complete suicide.
13. Suicide is a subject that one should rather not talk about.
14. Loneliness could for me be a reason to take my life.
15. Almost everyone has at one time or another thought about suicide.
16. There may be situations where the only reasonable resolution is suicide.
17. I could say that I would take my life without actually meaning it.
18. Suicide can sometimes be a relief for the ones involved.
19. Suicide among young people is particularly puzzling since they have everything to live for.
20. I would consider the possibility of taking my own life if I were to suffer from a severe, incurable disease.
21. A person once they have suicidal thoughts will never let them go.
22. Suicide happens without warning.
23. Most people avoid talking about suicide.
24. If someone wants to commit suicide, it is their business, and we should not interfere.
25. It is mainly loneliness that drives people to suicide.
26. A suicide attempt is essentially a cry for help.
27. On the whole, I do not understand how people can take their lives.
28. Usually, relatives have no idea about what is going on when a person is thinking of suicide.
29. A person suffering from a severe, incurable disease expressing wishes to die should get help to do so.
30. I am prepared to help a person in a suicidal crisis by making contact.

31. Anybody can commit suicide.
32. I can understand that people suffering from a severe, incurable disease commit suicide.
33. People who talk about suicide do not commit suicide.
34. People should have the right to take their own lives.
35. Most suicide attempts are caused by conflicts with a close person.
36. I would like to get help to commit suicide if I suffered from a severe, incurable disease.
37. Suicide can be prevented.

Scoring Instructions:

Subscales Defined by Norheim et al., 2016:

1. Avoidance of communication (#s 4, 7, 11, 12, 13, 19, 23, 27, 33)
2. Suicide is acceptable (#s 5, 16, 20, 29, 32, 34, 36)
3. Suicide is common (#s 14, 15, 25, 31)
4. Suicide can be prevented (#s 9, 30, 37)

Obtain scores for each of the subscales by averaging their respective questions.

Appendix C: The Perceived Spiritual Support Scale-Revised

The following questions address the time of a crisis (users can identify the disastrous event). Please indicate how much you agree or disagree with each statement using the scale below. (Note, you may replace the term God with another term more meaningful to you, for example, the divine, a higher power, eternity, the Supreme Being, Buddha, nature, the spirit, the Mother Earth, the life force, the ancestor, etc.) There is no right or wrong answer.

1= Strongly Disagree, 2= Disagree, 3= Agree, 4 = Strongly Agree

1. I have an inner resource from my spiritual relationship with God, or other spiritual/sacred source, that helped me face difficulties.
2. I experience the love and caring of God, or other spiritual/sacred source, on a regular basis.
3. I often feel close to God (or other spiritual/sacred source) in my heart.
4. My relationship with God, or other spiritual/sacred source, provides me with peace and contentment in uncertainty.
5. I have experienced a close personal relationship with God, or other spiritual/sacred source.
6. My profound love for God, or other spiritual/sacred source, has helped me to survive difficulty and distress.
7. I have received spiritual support from my religious congregation, or spiritual community.
8. My religious or spiritual faith has guided me through times of difficulty.
9. I have been inspired by my religious faith, or spiritual culture, in the face of distress.
10. My religious faith, or spiritual culture, has helped me cope during the time of difficulty.
11. I have gained inner strength from my religious faith, or spiritual culture, in the face of distress.
12. My religious faith, or spiritual culture, has provided me with comfort in uncertainty.

Please specify the spiritual higher powers in your faith or belief (You can circle more than one choice if you prefer).

1. God
2. Jesus Christ
3. An Angel
4. Virgin Mary
5. The Mother Earth
6. My Ancestor
7. The Energy Field

8. A Saint
9. The Cosmos
10. Buddha
11. Muhammad
12. Creator Spirit/s
13. The Dreaming
14. Songlines
15. Other (please specify):_____

Scoring Instructions:

Scores from each of the twelve items should be added together to calculate a total score from the scale. The highest score possible is 48, with higher scores indicating a greater sense of perceived spiritual support. No items are reverse scored for this scale.

Appendix D: Demographic Questionnaire

1. How do you currently describe your gender identity?

- Woman
- Man
- Non-binary
- Gender fluid
- Transgender
- Other (please specify): _____
- I prefer not to answer.

2. What is your age in years? (e.g., 19, 21, 23, etc.).

- Please specify: _____
- I prefer not to answer.

3. How many years have you been practicing therapy with clients? (e.g., 1, 2, 3, etc.)

- Please specify: _____
- I prefer not to answer.

4. Have you ever been a member of a crisis response team?

- Yes
- No
- I prefer not to answer.

5. What is your race/ethnicity?

- White
- Hispanic/Latinx
- Black
- Indigenous/Native American
- Asian/Pacific Islander
- Other (please specify): _____

6. What is your annual household income?

- Less than \$25,000
- \$25,000-\$50,000
- \$50,000-\$100,000
- \$100,000-\$200,000
- More than \$200,000
- I prefer not to answer.

7. What year did you graduate (or are expected to graduate) from your counseling program?

- Please specify: _____
- I prefer not to answer.

8. Was your counseling program accredited by CACREP?

- Yes
- No
- I prefer not to answer.

9. Did your graduate training include suicide assessment?

- Yes- training was adequate
- Yes -training was inadequate
- No
- I prefer not to answer.

10. What type of graduate training did you receive? (lecture, experiential, both, etc.)

- Please specify: _____
- I prefer not to answer.

11. Where is current counseling setting located?

- Midwest—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, North Dakota, South Dakota, Wisconsin
- Northeast—Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
- South—Arkansas, Alabama, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia
- West—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming
- I prefer not to answer.
- Other (please specify): _____

12. What type of geographical location is your counseling setting located?

- Rural
- Suburban
- Urban
- Other (please specify): _____
- I prefer not to answer.

13. How many suicide assessments do you complete in an average month?

- Please specify: _____
- I prefer not to answer.

14. What type of counseling setting do you practice within?

- Community Mental Health
- College Counseling Center
- Private Practice
- Alcohol/Substance Use Treatment Center
- Hospital
- School
- Long-term Care Facility
- Other (please specify): _____

15. What is your religious/spiritual affiliation?

- White evangelical protestant
- White protestant, not evangelical
- Black Protestant
- Catholic
- Jewish
- Muslim
- Hindu
- Buddhist
- Unaffiliated (atheist/agnostic)
- Other (please specify): _____
- I prefer not to answer.

16. How would you describe your participation in your religious/spiritual affiliation?

- Practicing
- Non-practicing
- No religious or spiritual belief
- Other (please specify): _____

17. How often do you attend religious services, apart from social events (i.e., weddings, funerals, circumcisions, christenings)?

- More than once per week
- Once per week
- Once per month
- Only at specific holy days
- Less often
- Never, practically never
- I prefer not to answer

18. Do you believe that other religions are more understanding of suicide than yours?

- Definitely yes
- Yes
- No opinion
- No
- Definitely no
- I do not know the viewpoint of other religions

19. Do you consider yourself to be a religious person?

- Yes
- No
- I prefer not to answer.

20. Do you consider yourself to be a spiritual person?

- Yes
- No
- I prefer not to answer.

21. How often do you turn to your religion/spirituality to help you manage problems in your life?

- Never
- Rarely
- Sometimes
- Often
- Always
- I prefer not to answer.

22. Over the past few months, to what extent have you had each of the experiences listed below?

- 1) not at all/does not apply 2) a little bit 3) somewhat 4) quite a bit 5) a great deal

"Over the past few months, I have..."

- a. Felt guilty for not living up to my moral standards regarding suicide risk interventions
- b. Worried that my clinical actions regarding suicidality were morally or spiritually wrong
- c. Felt torn between what I wanted for a suicidal client and what I knew was morally right
- d. Had concerns about whether there is any ultimate purpose to life or existence
- e. Felt troubled by doubts or questions about spirituality related to treating suicidal patients
- f. Worried about whether my beliefs about spirituality would negatively impact my ability to treat suicidal patients