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Perspective of Therapists on Religion and Spirituality in Therapy Work with Suicide Attempters in the United States: A Pilot Study

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ABSTRACT

Even though it is generally accepted that religion and spirituality (R/S) can play an important role in therapy, this study attempts to determine if this is indeed the practice and, if so, the extent that R/S plays among therapists who work with suicide attempters. Five mental health therapists from different faith backgrounds located in Santa Clara County, CA were recruited and interviewed. After employing the research method of Thematic Analysis, five themes emerged from the interview transcripts. The results from the interviews based on the themes suggested the following: (a) spirituality and religion were important in dealing with potential suicides, (b) it was important for the therapist to not impose their beliefs on the client but rather to support the client in their faith, and (c) there should be more training provided to therapists concerning religion. Also, the responses indicated that spiritual literature could be used to help clients and that therapists should find strength from their own faith.

Keywords

Therapists, Religion/Spirituality, Suicide attempters.

Studies suggest that religion or spirituality can be a protective factor or a risk factor in the mental health of persons with a high probability to die by suicide. There's data suggesting that most suicidal thinking resulting in plans is not actually implemented. However, past suicidal behaviours/attempts are strong predictors of completed suicides which marks suicide attempters as a high-risk group. There is a recognition of the need for a comprehensive approach that includes religion and spirituality (R/S) for follow-up care to suicide attempters.

Definitive studies in the literature showing the outcome of incorporating R/S in healing or therapeutic work with suicide attempters have been quite elusive and has been recognized not only as a risk factor but also as a protective factor to death by suicide [1-5]. This study is aimed at capturing the perspective of mental and behavioural health (MH) therapists regarding the ways in which R/S have come to play (or been integrated) in therapy with suicide attempters.

As a protective factor

Findings from at least five recent case-control studies that compared suicide attempters and non-attempters suggest the protective effect of R/S against suicide. One study [6] compared 18 years old and older outpatients with bipolar disorder with and without a history of suicide and found that the suicide attempters group had more comorbidity, more rapid cycling, higher levels of impulsivity, and less religious affiliation than the group without a history of suicide attempts. The researchers used a questionnaire and a structured clinical interview and administered them to the participants recruited from four specialized bipolar disorder treatment centres in Brazil. Findings from a retrospective case-control study with soldiers from the Israeli Defence Forces [7] indicated that having a non-Jewish religion was a moderate risk factor for suicide attempts along with low socioeconomic status, psychiatric disorders at induction, low intellectual rating scores, being born in the Soviet Union, and serving in non-combat units. The cohort of soldiers was divided into two groups: those soldiers who attempted suicide and those soldiers who did not make a suicide attempt.

A study by Akbari et al. [8] examined 300 cases (suicide attempters) and 300 age- and sex-matched controls (non-suicide attempters)

recruited from referrals by a hospital in the city of Kerman in southeast Ira. When adjusted for the experience of recent stressful life events, general health, close social network, problem-focused thinking, and intrinsic religiousness had a protective effect against suicide. Golshiri et al. [9] studied 175 Iranian individuals who presented themselves to a hospital emergency department for a suicide attempt and 175 individuals with no history of suicide attempts from the same hospital. They found that perceived social support and religion were protective against suicide attempts.

A case-control study with 91 cases (suicide attempters) and 270 controls from 6 health districts in rural Italy found that practicing religion was the only protective factor. The study examined the risk factors of living in isolated houses, living alone, not being married, low income, psychiatric pathology, psychotropic medication, problems with relatives, psychiatric family history, and suicidal ideation and the researchers found prevention strategies ought to target both socio-economic and clinical risk factors. A structured questionnaire was used to gather retrospective information from the general practitioners [10].

There are studies demonstrating that R/S (transcendence, gratitude, faith) positively played out as a buffer against attempting or reattempting suicide in times of depression [11] and hopelessness [12], stress [13], lack of support [14], alcoholism or risky behaviour [15], depression and isolation associated with religious affiliation or spirituality [16].

R/S had been found to be a deterrent to suicide attempts when R/S is a positively transforming experience in terms of having a positive representation of God, positive relationship or connection with God, existential well-being or belief in a supportive God; when the religious and spiritual faith is in intrinsic religious values, and not really in religious activities; and arguably, when R/S provides a grounding belief in the value of human life (moral objections to suicide) to resist the temptation to die by suicide.

As a risk factor

R/S along with the experience of isolation (loneliness, emptiness, and hopelessness) could indeed increase the likelihood of attempting suicide. Extremely traumatic experiences, aging, physical weakness, loss of independence, failed relationships (interpersonal conflict/violent arguments) and domestic violence, or occupational class/role expectations are other factors that increase the risk of suicide.

The experience of isolation could be brought about by stigma, not meeting role expectation, and socio-cultural conflicts [17-23]. In addition, the experience of isolation could also arise from being part of a religious community that is not welcoming of the following: cultural or religious minorities [24,25]; being different in having same-sex sexual attraction [26]; being lesbian, gay, bisexual or transgender (LGBT) [27-29].) or black LGB [30].

Extremely traumatic experiences and interpersonal relationships/violent arguments can also increase the risk of suicide. Pak [31] found a number of prisoners at war who died by suicide due to their inability to bounce back after experiences in war. Goodfellow et al. reported that natives in New Caledonia that engaged in violent arguments with a partner had a greater risk of suicide than those who didn't.

There have been suicide attempters who have experienced unresolved spiritual, divine, and existential struggles [3,32,33], or who have struggled with self-forgiveness [34-36], negative religious coping [32,36,37], hopelessness [38,39], moral transgressions/injury, and about the value or meaning and purpose of life [35,40]. In addition, there have also been suicide attempters who have suffered physical illnesses and endured dissatisfaction with life [41] or who questioned the value and purpose/meaning of life along with self or spiritual transcendence [40,42].

Additional factors

Data exists suggesting that most suicidal thinking and planning is not actually implemented [43] and there is data suggesting that past suicidal behaviours/attempts are strong predictors of completed suicides which marks suicide attempters as a high risk group especially within the first 6 to 12 months after a suicide attempt [44-56]. As such, it is critical for caregivers and loved ones of individuals with suicidal ideation to ensure their safety.

There is recognition of the need for a comprehensive approach to suicide that includes R/S domain or dimension to follow-up care for suicide attempters [57,58] and suicide prevention [47,59]. In addition, the acknowledgement of the importance of incorporating R/S in therapy [47], and awareness of suicide attempters having no regrets in life [60] are important ideas the mental health therapist ought to know.

Other than a study that found no difference in the effect of Cognitive Behaviour Therapy (CBT) on the reduction of suicidal thinking in persons with major depression and chronic medical illness [61] and a focus group study with health care professionals in Norway which focused on understanding practices of specialist healthcare professionals regarding existential themes in the treatment of people at suicide risk [62], studies showing the outcome of incorporating R/S in therapeutic work by therapists with suicide attempters have been limited.

Religion and spirituality can play a significant role in the lives of suicide attempters, serving as either risk factors or protective factors. Isolation, often brought about by stigma, is an important risk factor, along with social stress, stigma, and lack of access to resources. On the other hand, religion and spiritualty, such as being part of a caring congregation or an intrinsic believe in the value of human life, can serve as a buffer against attempting or reattempting suicide.

The Study Question

Given limited research exploring the outcome of incorporating R/S in therapeutic work by therapists, the study question is: how is R/S successfully integrated by therapists when working with suicide attempters?

Study Objective

This study aims to capture the perspective of mental and behavioural health (MH) therapists regarding the ways in which R/S has come to play (or been integrated) in therapy with suicide attempters, the challenges that emerged, and the personal lessons learned by the therapists in the process of working with suicide attempters. This study recruited licensed MH therapists who were from different R/S orientations and have worked with suicide attempters in the 12 to 48 months prior to this study. Working within the COVID-19 milieu, one-on-one interviews were conducted via telephone or with a secure online conference technology platform (Zoom).

Methodology

Participants

The study participants were recruited through the organized networks of National Alliance for Mental Illness Santa Clara County, Catholic Charities Santa Clara County, and through the Santa Clara Valley Chapter of the California Association of Marriage and Family Therapists. A flyer was created announcing the research study opportunity and requesting assistance (Appendix A). To qualify, the mental and behavioural health therapist must have been licensed or certified and needed experience working with suicide attempters in the 12 to 48 months prior to this study.

The targeted number of mental health therapist study participants was eight, including one individual from each of the religious/spiritual groups: Buddhist, Roman Catholic, Hindu, Jewish, Muslim, Protestant mainline Christians, Protestant non-denominational, or None. It is important to recognize that religious and spiritual practices are approached differently by people from differing faiths and in practice are often nuanced. After employing an extensive recruitment strategy, only five participants ultimately agreed to participate in the study. Their religious/spiritual affiliation can be found in Table 1 (note-one participant grew up Catholic but converted to Islam).

Table 1: Participants by Religious and Spiritual Group.

Non-denominal Christian	Roman Catholic	Protestant	Kriya Yoga/ Interfaith	Muslim
1	1	1	1	1

After participants were initially contacted, they were sent, via electronic communication, a consent form (Appendix B) and a screening questionnaire. The questionnaire asked for information concerning their license or certification, experience with working with suicide attempters, the time lapse from working with the last suicide attempter, the total number of suicide attempters, and their religious affiliation.

Table 2: Participants by License or Certification Type.

Associate Clinical Social Worker	Licensed Clinical Social Worker	Licensed Marriage Family Therapist
2	1	2

Data Collection

After consent forms and screening questionnaires were returned, a meeting time for a virtual conversation was scheduled. To ensure consistency, an interview protocol (see Appendix C) was used. Four of the five interviews were conducted via Zoom video conferencing; a fifth interview was conducted in person. After permission was granted, the interviews and discussions were audio recorded. The recordings were then transcribed using a transcription service and proof-read for accuracy. The audio recordings were then destroyed and the transcripts are stored on an encrypted computer.

Human Subjects Protection

The researcher complied with state and federal regulations as well as with Notre Dame de Namur University's Institutional Review Board (IRB) protocol regarding the confidentiality of study participants. Before beginning the interview, the study participants were reminded that they may pause or end the interview at any time they feel any discomfort.

Data Analysis

Data analysis was conducted using the method of Thematic Analysis, as outlined by Braun and Clarke [63], to identify common themes from interview transcripts. Thematic Analysis includes six steps: 1) becoming familiar with the data by reading and re-reading through the transcripts thoroughly; 2) creating initial codes by highlighting sections and assigning codes to describe the highlighted content; 3) looking for common themes by examining the codes and identifying patterns among them; 4) reviewing themes and making sure each theme is an accurate representation of the data; 5) naming and defining themes by developing a detailed analysis of each theme and naming it; and 6) producing a summary report. Roberts et al. [64] reference the importance of determining trustworthiness as an important step in ensuring applicability and utility, especially when research aims at informing practice. Validity, an important component of trustworthiness, can be achieved by a detailed account of procedures and methods. Thus, all of the actions in Braun and Clarke's steps were followed as much as possible to ensure fidelity.

Results

After completing the five steps data analysis, as outlined by Braun and Clarke [63], five overarching themes were identified. These themes include connecting therapy to faith, meeting clients where they are, use of spiritual/religious literature, importance of training in religion and spirituality, and incorporating spirituality outside of sessions.

Theme 1: Connecting therapy to faith

Overall, participants felt that religion/spirituality (R/S) is most successfully integrated by therapists working with suicide attempters when the therapist engages in conversations of R/S and a higher power when it is in the best interest of the client, including during use of various modalities such as DBT and CBT.

This theme was developed from 37 initial code assignments. Participant 3 stated, "I wouldn't bring up hell unless someone else brought up hell. I wouldn't bring up heaven unless someone else

brought up heaven." The therapist here recognizes the importance of letting the client lead and not imposing their personal beliefs on the client. This therapist went on to state, "if we can leverage religion, spirituality, and faith as a way of support for an individual going through a suicidal period, then let's leverage it and maximize it and resource it as much as possible". There is a desire here for the therapist to integrate religion, spirituality, and faith when it may prove beneficial to the client. Furthermore, participant 1 stated, "I stay strength-based in the conversation around their strengths and their abilities. I don't look at condemnation aspects of the dialogue".

Participant 5 stated
I think that is another important piece in just screening or asking right up front in the beginning of those sessions of like, do you have a faith tradition? Do you have a spiritual background that you identify with? Because those things I think can be extremely supportive.

Theme 2: Meeting clients where they are

In terms of integrating R/S, respondents emphasized the importance of meeting the client where he/she is at, while being aware when self-disclosure of his/her R/S may be helpful or harmful at the same time as recognizing the role of the therapist vs. a minister.

This theme was developed from 25 initial code assignments. Participant 3 highlighted this theme by stating
I think I try to find where a person is in their faith, whether they're Buddhist, whether they're…Whatever their faith is.... And so, it's just really supporting people where they are…I mean, the only thing that is me not sharing my personal specific beliefs is me holding... If it's not in the best interest of the client, I'm not going to disclose.

Similar to responses under theme 1, there is a recognition here by the therapist that it is important to meet the client where they are, and if that includes topics of R/S, great. If not, the therapist ought to steer away from topics in this area.

Participant 2 stated, "the work that I do, I move where the client is and so it wasn't an exacting moment for me, but it was for her because I moved with wherever she was at." In addition, Participant 5 stated, "I always was partnering with the chaplain at the hospital to try and see about how we could meet the needs of the patient". There is a general agreement that the needs of the client must come first and if those needs include conversations on R/S, then the therapist should be open to engaging with the client on those topics.

Theme 3: Spiritual/religious documents

In this theme, participants noted the value of therapists using scripture/literature from holy books as life lessons, thus incorporating a strength-based approach to assist in the therapeutic relationship.

This theme was developed from 10 initial code assignments. Participant 4 stated, "it seems that there is a lot of work around Eastern teachings, in regard to mindfulness, in regard to meditation. Those are always easier concepts to introduce". In addition, participant 5 stated

And so, when I was working with Muslim youth as a Muslim social worker myself, I think that I was really trying to pull from prophetic wisdom, mostly from the Quran, mostly from Hadith, which are like sayings of the prophet and just kind of lean into that kind of work.

Participant 2 stated
I did cover the scriptures that she felt close to but also, I was able to educate her and give her a little bit more depth of understanding and different scriptures. Sometimes the therapy, if you will, quote sessions would turn into more of a scripture reading, teaching education moments to, I believe, to be able to bring her into moments of better understanding of the in-depth Christianity that she already had within her, to give her another height of understanding about life and her, and what all that meant for her.

Holy books or other spiritual or religious documents can provide a source of comfort, or provide a source of pain, for clients. It is important for mental health therapists to be aware of and have a basic understanding of literature that clients might reference in their therapeutic sessions.

Theme 4: Importance of training in religion and spirituality

In this theme, participants spoke to the importance of therapists receiving training in understanding and incorporating R/S and cultural competency within the therapeutic relationship, including dogmatic beliefs of the afterlife and the understanding of the role of chaplains and other spiritual leaders in the recovery process. This theme was developed from 21 initial code assignments. Participant 5 stated, "when I went through my post grad certification process, spiritual identity is like one little part of what you learn. It's like we spend like a day on it, which is really unfortunate." This same participant further noted that she was always "partnering with the chaplain at the hospital to try and see about how we could meet the needs of the patient." In addition, participant 1 stated, "I think, as in a macro level, we need to do more with faith-based leaders, more training. On a macro level, we should run more clinics around Mental Health First Aid for faith-based leaders." Unfortunately, mental health therapists are given little to no training on R/S. Therapists that work for a faith-based organization may be provided training on specific religious or spiritual themes, ideas, or doctrines. Organizations such as NAMI, particularly their FaithNet effort, can oftentimes provide training to clinicians on issues of religion and spirituality.

Theme 5: Incorporating Spirituality outside of sessions

In this final theme, participants discussed the value of praying for or otherwise channelling spiritual energy to the client outside of actual sessions with the client.

This theme was developed from six initial code assignments.

Participant 4 stated

I pray rosary for them on my own, you know what I mean, asking for the Blessed Mother's help. If are Christian, then maybe I'll pray out of session. I'll do those extra, additional things for someone who is in deep suicidal ideation.

In addition, participant 5 stated
A lot of times how faith helped me most in those spaces, especially when I was working with suicidal mommies was really holding on to that thread of like, God is here in our room with us. me that gave me just strength as a therapist to carry forward, especially when mommies would pass off their dead babies to me and ask me to hold them in a moment of grace before they were taken away.

The power of prayer or directing spiritual energy to a client outside of a session can be very influential.

Discussion

Five therapists with different faith backgrounds were interviewed, and their responses were ultimately coded into five themes. The therapists came from Seventh Day Adventist, Catholic, Protestant,

Table 3: Themes and Codes.

Theme 1: Connecting Therapy to Faith	Theme 2: Meeting Clients Where They Are	Theme 3: Use of Spiritual/Religious Literature	Theme 4: Importance of Training in Religion and Spirituality	Theme 5: Incorporating Spirituality Outside of Sessions
Connect with faith	Meet client where client is at	Wisdom from holy books	Lack of spiritual training for therapist	Action outside therapist session
Connection to God	Understand where client is at	Identity with scriptures	Importance of training on role of spirituality in healing	Hope of therapist
Incorporate faith	Meet clients where they are	Helping client find strength through scripture and religion	Cultural competency training includes spiritual identity	Leaned on faith
How religion is introduced	Meet client where they are while amplifying connection to R/S	Using principles of Christianity/scripture in therapy to reinforce faith	Need more training for faith-based leaders	Religious beliefs of therapist define worldview
Resistance to religion	Personal religious belief	Using scriptural teachings in a non-religious way	Need training on cultural competence and other faiths	Spiritual practices of therapist
Role description	Personal faith journey	Using scripture to reinforce teachings	Use of learnings from graduate school in work with clients	
Religion role in therapy	Be careful bringing up spirituality	Using scripture stories to help with struggles	Concern from client about going to hell re. suicide	
Connection to faith or group	Concern about disclosing faith identity	Focus on strengths	Partnering with chaplain to meet needs	
Help connect to God	Later disclosed faith identity	Use strength-based approach with client	Partnership with chaplain	
Away from stigma and toward God	Client reaction to disclosure of faith identity	Create life worth living goals	Old dogmatic belief	
Recognizing God's presence	Cautious about interpreting and sharing faith		Avoiding suicide topics with Muslim youth	
Power of faith community	Therapist disclosure re. spiritual beliefs when in best interest of client		Trauma and worthlessness as spiritual attack	
Connection from faith community	Role of therapist vs. minister		Tools to address stumbling blocks	
Asking client upfront about faith tradition or spiritual beliefs	Probing level		Work of devil	
Understanding faith context of client	Psychoeducation of client		More acceptance of eastern spirituality	
Reactivity of clients when feeling uncomfortable with faith conversation	Reason for work		Accepted into heaven	
Conversation with client re. spirituality that might be damning or hurtful	Strength as therapist		Only God is perfect	
Absence of faith tradition and exposure to Christianity	Conflict between spirituality and psychosis		Religion reveals human perfection not possible	
Faith as protective factor	Concern about client being too far out there		Question faith as woman	
Work with spirituality of client	Struggle with client who refuses treatment		Work with specific populations, especially decentralized religions	
Spiritual energy of client	Back and forth on conflicting messages with client			
Suicide in context of spirituality	Seriously vs. situationally despondent client			
Leverage and maximize faith as support	Challenge with different worldview			

Getting feel from client about spirituality	Let client lead on religious principles			
Values-based model reflecting spiritual perspective	Therapist brings up spirituality based upon past discussions			
Lack of hope leading to suicide				
Presence of stigma in faith communities				
Inner wisdom connection to higher self				
Client wanting to show being spiritualty awaken but not grounded				
Spirituality saving client but frightening for therapist				
Therapist gets client to point of saving life				
Checking in with clients re. spiritual practices				
Spirituality discussions based upon urgency and timing				
Crisis survival skills come first, prayer later				
Re-attempter conversation				
Go deeper with client's spiritual being after attempt				
Incorporate religion in connection to DBT				
Discussion on prayer connected to DBT and larger worldview				
Help client with concrete DBT skills and less on spiritual in crisis				

Kriya Yoga, and Muslim traditions. It is important to survey mental health professionals representing different faith traditions because spirituality and religion are approached differently and in practice may have different nuances.

Most of the responses (37) indicated that spirituality and religion were important in dealing with potential suicides. Many therapists used religion and spirituality to help the client get beyond the immediate crisis and provide a means to prevent a future suicide attempt.

At the same time, the responses (25) indicated that it was important for the therapist to not impose their beliefs on the client but rather to support the client in their faith. The therapists indicated that they would make judgment calls regarding the amount of religious and spiritual information they would share with the client.

The third-largest group of responses (21) came from the theme of training therapists in religion and spirituality. Participants noted that there should be more training provided to therapists concerning religion, primarily in how to deal with the concept of hell related to suicide. In addition, many thought that therapists should be able to team with chaplains to address their clients' needs.

A total of ten coded responses were related to the theme concerning spiritual literature and five responses to the theme of incorporation of spirituality outside of the sessions. Several therapists suggested using spiritual literature to find the strength to continue with life. The responses to the theme of incorporating spirituality outside of the sessions seem to deal more with the therapists than the clients. Therapists ought to keep up their hope, and some pray for the clients.

While there were only five therapists who participated in this qualitative research project, across these therapists, it was clear that faith and spirituality were seen as essential in dealing with potential suicides. However, they also felt that clients should determine the degree of faith and spirituality, if any, that is incorporated into the therapeutic process. Most therapists agreed that more training was needed in the areas of spirituality and religion. It was also felt that religious literature can play a role in therapy and the therapists use their personal faith to find inner strength.

As was referenced in the literature section of this article, R/S had been found to be a deterrent to suicide attempts when R/S is a positively transforming experience in terms of having a positive representation of God, positive relationship or connection with God, existential well-being or belief in a supportive God; and when the religious and spiritual faith is in intrinsic religious values. In addition, R/S can provide a grounding belief in the value of human life (moral objections to suicide) to resist the temptation to die by suicide. The research findings of this pilot study are generally consistent with existing literature.

Clinical applications of this study suggest mental health therapists and those training mental health therapists ought be aware of implications of incorporating R/S into practice. These implications include: the therapist connecting therapy to faith, meeting clients where they are, use of spiritual/religious literature, importance of training in religion and spirituality, and incorporating spirituality outside of sessions.

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Appendix A: Recruitment Letter

An invitation to participate in a research Study

Research studies suggest that religion or spirituality can be a protective factor and a risk factor in mental health, wellness and recovery of persons who could be at risk for suicide. At the same time, there is a dearth of empirical research on the outcome of incorporating religion and spirituality in healing or therapeutic work with suicide attempters.

As such, **this study aims to capture the perspective of mental and behavioral health therapists regarding the ways in which religion and spirituality have come to play (or been integrated) in therapy with suicide attempters.**

Have you worked with any clients that have attempted suicide in the past 12 to 48 months (1-3 years)?

Do you identify as a member of a faith community and/or engage spiritual or religious practices in your work?

If you responded yes to these two questions, your participation in a research study is greatly appreciated!

Mental and behavioral health therapists are needed for a one-hour interview with the primary investigator.

Please contact the primary investigator Dr. Chris Miller for more information and/or to volunteer. **A $20 Starbucks gift card will be given to study participants that complete the one-hour interview.**

Appendix B: Consent Form

Title of Study: Perspective of Therapists on Religion and Spirituality in Therapy Work with Suicide Attempters
Investigator(s): Principal Investigator: Chris Miller, Ed.D.

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The investigator(s) explained the purpose and procedure of the study.

I understand that:

- The goal of the study is to better understand from the perspective of therapists (and others like me) who have worked with suicide attempters the role that religion and spirituality have played during therapy, and the challenges that emerged and the personal lessons I learned in the process of working with suicide attempters.
- This study entails my participation in a one-on-one interview via telephone or secure skype or zoom conferencing platform for up to 60 minutes long.
- The Study Investigator does not guarantee or promise that my participation in this study will personally or professionally be of benefit to me.
- By agreeing to participate in this study,
    1) I will be filling out basic demographic information about myself (age group, gender/orientation, religion/spiritual orientation) and information about my work with suicide attempters on an online survey, that will be treated as confidential, and
    2) I will be engaging in a one-on-one interview about my views on religion and spirituality in my therapy work with suicide attempters.
- I **consent** to the following for analysis by Study Investigators until the end of the Research Study:
    (1) the audio recording of my participation in one-on-one interview, and
    (2) the use of my data that were collected for this study.
- Reports to the public about this study will not personally identify me as participant. My name will not appear in any public reports.
- I can withdraw participation at any time. This will not have any effect on my personal and professional standing.
- Some personal distress may be triggered during the interview or discussion
- If the need for emotional support arises after the interview, I will contact any of the organizations below for information and/or referral:

Substance Abuse & Mental Health Services Administration (samhsa.org) at 1(800) 662-4357
Mental Health America (MHAmerica.org) at 1(800) 985-7990
National Alliance for Mental Illness (NAMI.org) at 1(800) 950-6264

My participation allows me to contact the Study Investigator and the Chairperson of the IRB, Dr. John Astin, by phone (831-332-3382 or email: jastin@ndnu.edu should I have any questions or concerns related to this study.
****

I DO GIVE MY CONSENT and AGREE to participate VOLUNTARILY in this study.

My name is: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date:

Appendix C: Interview Schedule

Introduction

My name is Chris Miller. I am the principal investigator on this study. We have communicated via email/telephone. As you would kindly recall, the goal of the study is to better understand from the perspective of therapists like you who have worked with suicide attempters the ways in which religion and spirituality have come to play a role during therapy, the challenges that emerged and personal lessons you learned in the process of working with suicide attempters. So, there are no right or wrong answers.

This one-on-one interview will run up to an hour. If at any time, you feel any discomfort, just let me know, and we can pause and then continue with the interview or end the interview. I will be recording the interview with a mini-tape recorder that is independent of the iPhone/county telephone devices.

Again, if the need for emotional support arises after the interview, please contact any of the organizations listed in the consent form for information and/or referral:

SAMHSA (www.samhsa.org) at 1(800) 662-4357
Mental Health America (MHAmerica.org) at 1(800) 985-7990
National Alliance for Mental Illness (NAMI.org) at 1(800) 950-6264

Brief pause

Interview or Discussion Proper

I understand that you (all) have experienced working with suicide attempters.

A. Let's first focus on your experience working with suicide attempters with whom you sensed improvements, by that let's say no attempt was made for at least one year from when you started working with this/these person(s).

1. Would you kindly describe in what ways religion and/or spirituality played a role in your therapy work with this/these person(s). How did the conversation in relation to religion or spirituality come up?
2. Was there anything related to religion and/or spirituality that you think in hindsight might have been important but did not come up? Follow up: Were there any particular challenges/barriers to bringing that up? Anything that held you back? (When would it be appropriate to bring it up?)
3. Was there anything about religion and/or spirituality that you did talk about, but looking back you feel would have been better to have not discussed?
4. Is there anything related to religion and/or spirituality that you would tend not to talk about with clients?
5. In the course of doing therapy with your clients, did you experience any particular challenges in your conversations related to spirituality and/or religion?
6. Any thoughts (personal lessons learned) or recommendations?

Closing: This concludes our interview/discussion. Thank you very much for your participation. Do you have questions or other "things" that you would like to raise?