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Religious Coping and Spiritual Struggle Among Emergency Room Patients with Suicidal Intent

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Religious Coping and Spiritual Struggle among Emergency Room Patients with Suicidal Intent

by

Rosanna J.S. Bailey

Presented to the Faculty of the
Graduate Department of Clinical Psychology

George Fox University

in partial fulfillment

of the requirements for the degree of

Doctor of Psychology

in Clinical Psychology

Newberg, Oregon

April 20th, 2016

Religious Coping and Spiritual Struggle among Emergency Room Patients with Suicidal Intent

by

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has been approved

at the

Graduate Student of Clinical Psychology

George Fox University

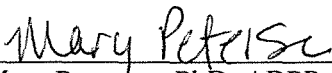
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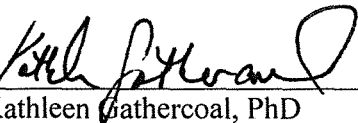


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Abstract

Suicide continues to be a leading cause of death around the globe (World Health Organization, 2012; Wu, Wang, Jia, & Mazza, 2015). Previous literature has shown religiosity as a protective factor for depressive symptoms and suicidal ideation (Dervic et al., 2004; Dew et al., 2010; Miller et al., 2012; Nonnemaker, McNeely, & Blum, 2003; Rasic et al., 2009; Rosmarin et al., 2012), and that spiritual struggle is associated with increases in suicidal ideation (Ahles, Mezulis, & Hudson, 2016; Henslee et al., 2014; Lee, Nezu, & Nezu, 2014; Rosmarin et al., 2013; Stratta et al., 2011; Trevino, Balboni, Zollfrank, Balboni, & Prigerson, 2014). However, studies by Huguelet et al. (2007) as well as Lawrence et al. (2016) indicated that in some cases, positive religious coping may be associated with risk factors for suicidality. The present study explored aspects of spiritual struggle or religious coping that were spontaneously offered and noted in a medical record during a standard emergency room risk assessment involving the Collaborative Assessment and Management of Suicidality. Among 839 archival records from emergency department settings in Yamhill County, Oregon in 2015 and 2016, only 36 interviews met criteria. It was hypothesized that those with expressed spiritual or religious struggle would

indicate a higher risk for suicide through self-report, compared with those who express positive religious coping. The current study found no association between self-report of suicidal intent severity and style of spiritual or religious coping. The number of interviews that met criteria were far fewer than predicted. Several possible explanations are considered.

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Chapter 1

Introduction

Suicide is among the top three universal causes of death among 15-44 year olds (Wu, Wang, Jia, & Mazza, 2015). As of 2012, it is estimated approximately 800,000 suicide deaths occur worldwide each year, averaging approximately 11 individuals for every 100,000. Suicide by comparison, outnumbers the average number of homicide deaths globally by approximately 2:1 (World Health Organization, 2012). One protective factor against suicide attempts, suicidal ideation, and related depressive symptoms, is religiosity and spirituality, which has been identified repeatedly in the literature (Dervic et al., 2004; Dew et al., 2010; Miller et al., 2012; Nonnemaker, McNeely & Blum, 2003; Rasic et al., 2009; Rosmarin et al., 2012).

Although they are often referred to interchangeably, religion and spirituality represent related but different human experiences. Koenig (2012, p. 3) referred to spirituality as “the personal quest for understanding for life’s ultimate questions and the meaning and purpose of living.” Spirituality is a common existential pondering which may increase during times of crisis. Religion is defined as “an organized system of beliefs, practices, rituals, and symptoms designed to facilitate closeness to the sacred or transcendent” (Koenig, 2012, p. 2). Religion is an important aspect of culture globally in that establishes social power structures, communities, and a clear moral code that enable individuals to increase conformity to the desired behaviors to gain deeper meaning of existence. This established code and structure also provides a guide to

corrective responses and potential increased support to those who stray (Agorastos, Demiralay, & Huber, 2014).

In the United States, approximately 52% identify religion as “very important” and about three out of four Americans identify as “Christian” (Gallup, 2015). Approximately 22.8% of Americans identify as unaffiliated including such categories as “atheist”, “agnostic”, or “nothing in particular” (Pew, 2015). While mainstream Christian denominations have declined from 78.4% in 2007 to 70.6% in 2014 (Pew, 2015), during the same time period research has emerged showing that individuals who engage in spiritual and religious practices tend to show increased health behaviors (Guilfoyle & Pierre-Hansen, 2012; Koenig, 2012; Nonnemaker et al., 2003), increased life expectancy (Hummer, Rogers, Nam, & Ellison, 1999), and increased work performance (Newport, 2013).

When considering suicidality, religion and spirituality warrant consideration for at least three reasons. First, religion and spirituality appear to be related to depression, which is, in turn, is related to suicidal thoughts and behaviors. Second, religion and spirituality may be a direct protective mechanism for suicidal thoughts and behaviors. Third, how a person relates to his or her religious or spiritual beliefs, either by spiritual struggle or by religious coping, may indicate a warning sign for suicidality.

Religion, Spirituality, and Depression

Many studies have shown religion to be a protective factor for depression (Maselko, Gilman, & Buka, 2009; Miller et al., 2012; Schettino et al., 2011). A large meta-analysis by Smith, McCullough, Poll and Cooper (2003) showed religion had a small, but significant effect on depression, with religion being inversely related to depression. More recent studies affirm this relationship between depression, religion, and spirituality. For example, after controlling for

substance abuse and social support, items involving loss of faith, lack of forgiveness, negative religious support, and negative religious coping retained significant positive correlation to the Beck Depression Inventory- 2nd edition (BDI-II) scores within an adolescent inpatient population (Dew et al., 2010). Moreover, loss of faith predicts less improvement in depression scores over 6 months, and may be a marker of poor prognosis among youth suffering from depression (Dew et al., 2010).

A longitudinal study of women in families with history of depression indicates that those who attended church regularly show less symptoms of depression and are less likely to have a need psychopharmacological intervention for depression independent of their social adjustment (Barton, Miller, Wickramaratne, Garmeroff, & Weissman, 2013). Miller et al. (2014) found for this same population, studied via MRI twice in five years, that those individuals who indicated religion as “more important” showed an increase in cortical thickness in left and right parietal and occipital regions of the brain, as well as the mesial frontal lobe of the right hemisphere and the cuneus and precuneus in the left hemisphere. Their findings showed a 90% decrease in the risk of depression independent of family history.

The effects of religious involvement may be different among various racial groups. For example, church attendance and involvement are related to less reported depression overall among African Americans in comparison to other racial groups (Hudson, Purnell, Duncan, & Baker, 2015; Reese, Thorpe, Bell, Bowie, & LaVeist, 2012). Church attendance multiple times a week has also been shown to be associated with overall life expectancy across ethnicities, however among African Americans, church attendance is associated with up to 14 more years of life expectancy (Hummer et al., 1999).

Within an inpatient geriatric population, intrinsic religiosity is associated with lower depression scores over time (Paymen & Ryburn, 2010). Among an inpatient psychiatric population of those with psychosis, Rosmarin et al., (2012) found that those with a belief in God were associated with improved treatment outcomes, decreased behaviors of self-harm, decreased symptoms of depression, and an overall sense of well-being over time.

Religion, Spirituality, and Suicide

Research on the protective effects of religion for suicidality reveal mixed findings. Various perspectives are important to consider, including religion as a motivating factor for suicide. Huguelet et al., (2007) found within a population of patients with a diagnosis of schizophrenia or schizoaffective disorder religion has no significant effect on suicidality, although 25% reported it to be protective. Conversely, approximately 1 in 10 inpatients cited religion as an incentive for suicide, indicating comfort in the hope of life after death. In a population of clinically depressed patients, high religious involvement was associated not only with increased suicide attempts, but also increased hospitalizations, antidepressant switches, prescription of tricyclic antidepressants, family history of depression, and a comorbidity of obsessive compulsive disorder (Azorin et al., 2013).

Lawrence et al. (2016) found religious affiliation, attendance, and the self-reported importance of religion to be associated with increased suicide attempts and ideation in a population of 321 adults of inpatients and outpatients diagnosed with major depression or bipolar disorder. In contrast, Svob, Reich, Warner, and Weissman (2016) reported that religious affiliation mitigated the likelihood of suicide completion among children and adolescents.

The relationship between suicide and religion may vary with culture. Wu et al. (2015) suggest that results of religiosity vary between Western and Eastern culture. A psychological

autopsy report of Chinese men who had died by suicide in a rural province showed religiosity to be higher among those who died than among the controls (Zhang, Xiao, & Zhou, 2010). In contrast, Wu et al. (2015) suggest that religion may serve more of a protective function in Western civilization's religiously homogeneous communities, and in populations of older adults. Consistent with this, Deveric et al. (2004) reported the prevalence of suicide attempts across the lifetime in a population of inpatients suffering from depression increases the odds of the attempt, but the number of attempts is mitigated among religiously affiliated inpatients. Additionally, for individuals with a mental illness who identified as spiritual or religious or both, overall decreased suicide attempts were found independent of the effects of social support (Rasic et al., 2009).

Religious Coping

In general, religious practice is associated with increases in meaning, control, and comfort in stressful situations (Pargament, 1997). When religion fails to provide these, individuals may choose to transform their religious practices into coping styles. Religious coping has been a topic of extensive study. Religious coping, first conceptualized by Pargament (1997), is defined as "the use of religious beliefs or behaviors to facilitate problem-solving to prevent or alleviate the negative emotional consequences of stressful life circumstances" (Koenig, Pargament, & Nielsen, J., 1998, p. 2). In this way individuals engage collaboratively with their deeper beliefs in god, spirit, or other deeper power in order to facilitate problem solving processes and enhance empowerment (Pargament, 1997).

Religious coping is divided into styles of positive and negative. More recently, negative religious coping has been referred to as spiritual struggle (Exline, Pargament, Grubbs, Yali, & Piedmont, 2014). Positive and negative coping generally lead to positive and negative

psychological adjustment, respectively (Ano & Vasconcelles, 2005; Pargament, Koenig, Tanakeshwar, & Hahn, 2004; Tetteri & Glenwick, 2013). Positive religious coping leads to a collaborative process with God and spiritual leaders and increases the experience of empowerment that may fuel a recovery process through the troubling situation (Yangarber-Hicks, 2004). Individuals differ in religious coping and do not uniformly utilize positive or negative coping for specific situations. Indeed, many utilize a combination of both positive and negative coping strategies for a given situation (Schottenbauer, Rodriguez, Glass, & Arnkoff 2006).

The concept of negative religious coping is closely aligned with the newer construct of religious and spiritual struggle (Exline, Pargament, Grubbs, Yali, & Piedmont, 2014; Exline & Rose, 2013). Even a decade ago, McConnell, Pargament, Ellison, and Flannelly (2006) identified negative religious coping as a form of spiritual struggle that has significant links to anxiety, depression, paranoid ideation, obsessive-compulsiveness, and somatization. Religious and spiritual struggles include struggles with the divine or the demonic, interpersonal or intrapersonal challenges with a higher power or members of the faith, moral struggle, struggle with doubt, or struggle for ultimate meaning (Exline et al., 2014). The purpose of the current study was to explore if these beliefs bear some weight in the decision making process of suicide.

Negative religious coping, or spiritual struggle, has been associated with increased suicidal ideation (Ahles et al., 2016; Henslee et al., 2015; Lee, Nezu, & Nezu, 2014; Rosmarin et al., 2013; Stratta et al., 2011; Trevino, Balboni, Zollfrank, Balboni, & Prigerson, 2014). In populations exposed to a recent natural disaster, suicidal ideation was associated with an increase in spiritual struggle (Henslee et al., 2014; Stratta et al., 2011). This indicates that severe and prolonged environmental stress may challenge spiritual or religious beliefs and thus become a

risk factor for suicide. Among patients with advanced stages of cancer with a life expectancy of six months or less, those with increased spiritual struggle are robustly correlated with suicidal ideation even after controlling for mental and physical health, self-efficacy, secular coping, social support, spiritual care, global religiousness and spirituality, and positive religious coping (Ahles et al., 2015; Trevino et al., 2014). Similar results of increased suicidal ideation were found among a population of individuals who had acquired immunodeficiency syndrome (AIDS) or the human immunodeficiency virus (HIV). Those with higher suicidal intent and higher depressive symptoms were associated with negative religious coping. In contrast, positive religious coping was associated significantly with positive affect and life satisfaction, although it was not associated with overall depressive symptoms or perceived quality of life (Lee et al., 2014). In a population with severe and persistent mental illness, Rosmarin et al. (2013) show positive religious coping was associated with significant reductions in depression and anxiety among patients with psychosis, and spiritual struggle was associated with increases in suicidal ideation, depression, anxiety, and wellbeing. This demonstrates that those patients with psychotic pathology, spiritual struggle may be a motivating force for suicide. Alternatively, positive religious coping may be a protective factor.

Collaborative Assessment for Management of Suicidality

Research by Harris, McLean, Sheffield, & Jobes (2010) indicates nearly all 1,000 suicidal individuals within the study engage in an internal debate, to live or to die. This internal debate may often include a behavioral component, including researching plans or connecting with other suicidal persons online. Those afflicted by suicidal ideation may be ineffectual in engaging cognitive faculties to the debate due to mental illness (Jobes, 2012). The Collaborative Assessment for Management of Suicidality (CAMS) includes a mechanism to have patients

complete two columns to identify ambivalence. These columns include: reasons for living and reasons for dying. The CAMS is an assessment and intervention created to increase ambivalence and to engage suicidal patients in rational conversation through therapeutic alliance and enhanced coping (Jobes, 2012).

The present study explored the spontaneous identification of religious and spiritual factors that are listed as reasons to live or die on completed CAMS among a population of patients who have visited the emergency department in Yamhill County, Oregon within the last two years. The religious or spiritual content was identified and coded as positive religious coping or spiritual struggle. It was predicted that both positive religious coping and spiritual struggle would contribute to predicting overall self-reported suicide risk.

Chapter 2

Methods

Participants

I explored archival data from previous CAMS assessments from January 2015 to December 2016. Records were de-identified and coded according to their initials and date of birth. Individuals with repeated CAMS administrations were selected only once for inclusion in the data set (the administration selected was chosen by random number generator). Inclusionary criteria involved the completion of CAMS Risk assessments of suicidal individuals by a clinician who recorded a religious or spiritual issue, either as a reason to live or die. Of the 839 archived interviews, only 36 (4.3%) met the criteria, which is far lower than the estimated 150 interviews that would meet the criteria. Of the 36 participants, 10 were identified on the CAF as Male (29%), 25 as Female (71%). The ethnicity of the participants included 82.9% European American, 5.7% Hispanic, 2.9% African American, 2.9% Asian American, and 5.7% other. Of the toxicology screens 22.9% of the participants were positive for alcohol use, 31% positive for THC, 20% positive for Benzodiazapenes, 9% positive for opioids, 11% positive for Amphetamine, 5% positive for Oxycodone, and 3% positive for some other potential intoxicant. Of the 36 individuals, 13 individuals were negative for any toxicology. Among the participants 71% (25) met criteria for major depressive disorder, 37% (13) for a substance use disorder, 8.6% (3) for trauma related disorder, 14% (5) for Anxiety disorder, 11% (4) for psychosis, 2.9% (1) for Dementia or other neurological disorder, and 2.9% (1) for other disorder.

Instruments

The Collaborative Assessment and Management of Suicide (CAMS) is a program of therapeutic intervention specifically developed by Jobes (2012) to treat suicidality. The Suicide Status Form (SSF) is the core assessment used to indicate severity of suicidal symptoms at the initial intake, as well as a method to track intensity throughout the CAMS program of therapeutic treatment (Corona et al., 2013). In previous studies, Jobes, Jacoby, Cimboric, and Husted (1997) demonstrated significant pre/post within-group differences using the SSF among a group of 106 college students with suicidality. The SSF showed good convergent validity, all correlations were statistically significant and ranged from $r = .25$ to $r = .75$. Additionally the multivariate analysis of variance showed strong criterion-related validity with the six rating scale items being significantly elevated in groups of suicidal patients in relation to responses from non-suicidal participants. Test-retest reliability of the SSF ratings ranged from acceptable to good with correlation coefficients ranging from $r = .35$ to $.69$ (Conrad et al., 2009). Jobes, Kahn-Greene, Greene, and Goeke-Morey (2009) also showed significant reductions in overall symptom distress and suicidal ideation with repeated measures linear analyses after CAMS intervention. The SSF form consists of a number of items related to suicidal symptoms and thought processes. The patient reports the intensity of specific drivers of suicide including psychological pain, stress, agitation, self-hatred, and overall risk of suicide as well as a qualitative descriptions of reasons for living (RFL) and reasons for dying (RFD; Jobes, 2012). For the purposes of the current study, only the SSF (see Appendix A) was considered.

For additional data regarding any religious or spiritual content, the standard emergency room interview report known as the Crises Assessment Form (CAF) was considered. All qualified mental health professionals were trained by Yamhill Community Mental Health to

gather the same pertinent information to determine the level of risk a patient present to him or herself or to others. The CAF is a tool to guide this process and also to organize the note written after the interview. The CAF includes demographic information, presenting concern, and occasionally will identify the spiritual orientation of the patient. The Suicide Adult Assessment Protocol (SAAP; Fremouw, Tyner, Strunk, & Mustek, 2005) is a measure of suicide risk embedded within the CAF as a way of gathering the pertinent contextual, historical, and demographic risk factors of the patient as a way of determining the level of risk ranging from low to high. For the purposes of the current study, only those recorded content items in direct reference to religious or spiritual content were recorded from the CAF.

Procedure

Data were collected from the standard intake interview questions within the CAF as well as the CAMS Suicide Status Form (SSF), including spiritual orientation, psychological distress, stress, agitation, self-hatred, and overall self-reported risk of suicide. Any religious content recorded in the standardized interview was also considered. For the purposes of this study, religious or spiritual content included all references to God, Jesus, spirit, afterlife, heaven, hell, demon, angels, the universe, karma, mother-nature, or other related spiritual, sacred, or supernatural content. Data were recorded under date of interview and medical record number and then de-identified using only the last 4 numbers of the medical record number prior to data analysis.

Grounded theory was utilized to code the content expressed in the qualitative sections of the CAMS of the SSF within the section for reasons for living (RFL) and reasons for dying (RFD). Table 1 and Table 2 display the categories that were developed by a team of six. Of the six individuals, five individuals provided coding of categories expressed by patients. Overall, the

five raters agreed 75.2% of the time on the categories for reason for living, and 75.6% of the time for reasons for dying

Table 1

Inter-Rater Reliability for RFL

Reasons for Living	Occurrence in Sample	Average Inter-Rater Reliability
Close family relationships	25	92.8
Social Support	11	57.5
Divine Being	11	83.3
Faith Community	6	71.1
Religious Practices, Beliefs	5	57.7
Fear (Death, consequences)	3	86.6
Pets, animals	4	95.0
Care for self (self-care, goals, future plans)	6	80.0
Care for others (service, not wanting to hurt people)	6	58.0
Aesthetics (art, beauty, music)	3	70.0

Note. Five raters were used to determine what factors applied to each patient who expressed RFL.

Table 2

Inter-rater Reliability for RFD

Reasons for Dying	Occurrence in Sample	Average Inter-Rater Reliability
Escape physical suffering	6	72.5
Escape psychological suffering	12	63.2
Reunion with loved one	8	95.0
Anticipating positive afterlife	2	73.3
Religious trauma	1	100.0
Burden to others	5	92.0
Shame and Failure	10	76.4
Anger toward others	1	80.0
Lack of resources	2	40.0
Lack of meaning	3	63.3

Note. Five raters were used to determine what factors applied to each patient who expressed RFD.

Chapter 3

Results

Of the 839 archived interviews, only 36 (4.3%) met the criteria ($N = 36$). The low pool of participants foreclosed options to complete a regression analysis. A series of independent samples t -tests were found to be statistically non-significant for the dependent variable of self-reported suicidal intent with the independent variables being those who identified positive religious coping or spiritual struggle as reasons to live or die.

There was no significant difference in reported suicidal intent between those who identified positive religious coping as a reason for living, $M = 2.62$, $SD = 3.85$, $N = 17$, and those who did not identify positive religious coping factors as a reason for living, $M = 3.14$, $SD = 3.59$, $N = 14$; $t(29) = .390$, $p = .93$, n.s., Cohen's $d = 0.14$). There was no significant difference in the reported suicidal intent level for those who identified positive religious coping factors as a reason for dying, $M = 3.50$, $SD = 4.14$, $N = 8$, and those who did not identify positive religious coping as a reason for dying, $M = 2.63$, $SD = 3.58$, $N = 23$; $t(29) = 0.57$, $p = 0.35$, n.s.; Cohen's $d = 0.22$). Neither effect size was found to be meaningful according to Cohen's (1988) convention. Similarly, there was not a significant difference in the reported suicidal intent level for those who identified spiritual struggle as a reason to die, $M = 0.25$, $SD = 0.50$, $N = 4$, and those who did not identify spiritual struggle factors as a reason to die, $M = 3.24$, $SD = 3.79$, $N = 27$; $t(29) = 1.55$, $p = 0.132$, n.s.; Cohen's $d = 1.10$). The effect size for this analysis exceeded Cohen's (1988) convention for a large effect size, but caution should be taken in interpreting this finding because

of the low sample size in the analyses. No participants expressed any items related to spiritual struggle as a reason to live.

Chapter 4

Discussion

The original purpose of this study was to determine if positive religious coping or spiritual struggle influenced the severity of reported suicidal intent. Unexpectedly, the results of this study were inconclusive due to the limited number of participants whom had religious or spiritual content recorded within their risk assessment. Several possible explanations are presented here.

Explanation 1. *Patients have an inner experience of religion and spirituality and express related content, but these are not recorded within risk assessments by interviewers.*

One possibility is that very little religious and spiritual content was documented despite what may have occurred in the actual clinical interview. Previous literature has indicated that highly educated individuals tend to be less religious and less inclined to consider religious and spiritual factors in daily life (Delany, Miller, Bisoño, & Roberts, 2007; Shafranske & Malony, 1990; Zuckerman, Silberman, Hall, 2013). In institutions and settings of highly educated individuals, secularity is the norm, and religious or spiritual content may be more likely to be ignored, disregarded, pathologized, or even disrespected. Of note, all the interviewers are George Fox masters level graduate students in doctoral training for clinical psychology. George Fox University is a Christian school and is affiliated with an evangelical Quaker denomination. Students are required to take several courses related to engaging with spiritual and religious issues in their personal life as well as as a professional. At Christian schools training graduate

students in clinical psychology, Fisk et al. (2013) have shown that in later years, students identified less reliance on God and religious practice than they showed early in training. It is possible that the George Fox interviewers are focused on collecting measurable data and less concerned with the ambiguity of religious and spiritual factors. Conversely, it may be that as consultants from a Christian university, interviewers are aware that documentation involving religious or spiritual content may be disregarded among the highly educated professionals of physicians, psychologists, nurses, and psychiatrists.

Explanation 2. *Patients have an inner experience of religion or spirituality but choose not to express related content because of inhibiting factors.*

Participants may be reluctant to share content related to religion and spirituality for a variety of reasons. It is culturally evident that within most societies of the United States of America there exists a distinct separation between religious spaces and secular spaces. Spaces designated for specific uses may decrease the likelihood of expressed behaviors that are not consistent with the role of the environment. Additionally, policies of designated spaces may decrease non-normative social behavior. The medical environment communicates specific expectations of behavior and may include a meta-communicated belief that personal religious and spiritual beliefs are unwelcome or simply required to be kept silenced. Miller (2015) proposes in a TED talk that medical settings provide anesthetic, which not only numbs pain but also removes reminders of those aspects of daily life that remind a person of their values, beliefs, and personal meaning. In other words, things related to aesthetic art, religion, personal meaning, may be absent from a hospital in order to better serve utility and purpose of medical procedure. If the risk assessment was completed within a place of faith practice, soft room with art, or in the presence of a chaplain or clergy member an individual may be more likely to express religious or

spiritual content because the environment will provide signals that personal expressions of beliefs are congruent with the environment, and it is more likely that these beliefs will be received with respect.

Additionally, it may be that participants do not express personal religious or spiritual beliefs unless directly prompted within the risk assessment. Interviewers may not prompt individuals about their spiritual or religious beliefs believing that the patient will spontaneously offer content if it is important. This may be reflective of personal beliefs and/or time constraints of the interviewers.

One possibility for this may involve the belief of the interviewer that religious or spiritual beliefs have no influence on the severity of expressed suicidality and such a conversation may be lengthy and not beneficial to the patient. Another possibility may be due to the belief that the risk assessment may be sidetracked or hijacked to a discussion about religion or spirituality in a way that is unhelpful to the purpose of the assessment. Patients may respond in overly positive or negative ways to the interviewer when religious or spiritual questioning occurs, which may alter the appropriate level of rapport necessary to complete a thorough determination of the patient's needs.

Explanation 3. *Patients have little or no inner experience of religion or spirituality and therefore do not express any related content.*

Participants may be reluctant to share content related to religion and spirituality for a variety of reasons. It is culturally evident that within most societies of the United States of America there exists a distinct separation between religious spaces and secular spaces. Spaces designated for specific uses may decrease the likelihood of expressed behaviors that are not consistent with the role of the environment. Additionally, policies of designated spaces may

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Implications

Although it is not possible to determine which of these three explanations best accounts for the lack of religious and spiritual content in the archival data used for this study, both research and clinical implications should be noted. With regard to research, further study needs to explore the ways that religion and spirituality may protect or drive suicidality. In addition, it will be important to study how effectively and efficiently the religious and spiritual content of Emergency Department conversations are being recorded in medical records. Regarding a clinical implication, because medical settings include highly educated individuals who may be less likely than others to espouse personal religious or spiritual beliefs, it would behoove the

medical community to have a validated screener or short assessment tool to identify how religious coping and spiritual struggle may be evidenced within expressed risk for suicidal behaviors. In this way, someone who does not espouse religious or spiritual belief may determine the level of danger for a person who identifies religious or spiritual content as a reason to live or die. Still, no assessment tool will replace a competent interviewer who is well informed of the literature for at-risk populations, warning signs, and environmental drivers which may propel an individual to consider ending their life prematurely. Interviewers need both training and encouragement to consider religious and spiritual assessment questions as part of risk interviews. In doing so, they may be able to capture components of a human life that seem to be either unrecorded, hidden, or ignored within many healthcare settings. This provides valuable information about how a patient functions, views the world, and experiences meaning.

Limitations

The limitations of this study include generalizability concerns and interviewer differences. This study was conducted in rural Yamhill County, Oregon which does not reflect the demographics of most counties in the United States. Yamhill County is 715.86 square miles. The largest towns are Newberg and McMinnville with many smaller towns, rural, and agricultural areas (United States Census Bureau: Yamhill County, Oregon [U.S. Census Bureau], 2015). Yamhill County has an estimated population of 102,659 and is primarily European American with an estimated 91.9% identifying as White (U.S. Census Bureau, 2015). Within this population 87.5% of persons age 25 years or more graduated from high school, and 23.2% achieved Bachelor's or higher degrees (U.S. Census Bureau, 2015). Additionally, 10.9% are under 65 years with a disability, 11.7% without health insurance under age 65, and 13.3% (13,653) are living in poverty (U.S. Census Bureau, 2015). Given the high percentage of

European Americans, economic disparities, and population of this county, the results of this study may not be well generalized to areas that are more urban, more rural, or more ethnically diverse.

Another limitation of the study relates to the interviewers. While all interviewers were all employees of the George Fox Behavioral Health Consultation Team and were provided the same training, there is no guarantee each interviewer is asking the same questions or documenting the same information. Individual clinical judgment, personal differences, and individual countertransference in response to patients may influence what questions are asked and what information is recorded. Although all interviewers have had extensive coursework in spiritual and religious issues and questions related to religion and spirituality have been present on the CAF, it is not clear if interviewers are asking explicit questions related to religion and spirituality. Future studies should train interviewers specifically to ask religion and spirituality questions respectfully and to document the resulting conversations in relation to risk factors or warning signs.

Conclusion

Positive spiritual and religious experiences have been associated with mitigating depressive symptoms and increasing psychosocial adjustment, health behaviors, and life expectancy. The research concerning religious and spirituality and its relationship to suicidality is both limited and mixed. The purpose of the current study was to explore if positive spiritual or religious coping or spiritual struggle influenced self-reported suicidal severity.

The results of this study offer no clarity to this question. Instead, more questions have been generated about the lack of documented religious or spiritual factors expressed by patients. It is possible that the interviewers did not record expressed religious or spiritual content offered

by patients experiencing suicidality, patients with suicidality did not offer their religious or spiritual beliefs in the course of the interview, or patients do not prescribe to spiritual or religious beliefs, making religious and spiritual content irrelevant to most risk assessments.

Spiritual and religious beliefs are often regarded as a diversity or cultural aspect of an individual and groups. Highly educated professionals may feel ill prepared to engage these conversations and may be unfamiliar with how a practice or belief may interact in an individual's life. Developing useful screening measures to explore when a spiritual or religious belief may become a barrier or motivator to healthy recovery may be important to for further treatment and support of suicidal patients.

References

- Agorastos, A., Demiralay, C., & Huber, C. (2014). Influence of religious aspects and personal beliefs on psychological behavior: Focus on anxiety disorders. *Psychology Research and Behavior Management, 7*, 93-101.
- Ahles, J. J., Mezulis, A. H., & Hudson, M. R. (2016). Religious coping as a moderator of the relationship between stress and depressive symptoms. *Psychology of Religion and Spirituality, 8*(3), 228-234. <http://dx.doi.org/10.1037/rel0000039>
- Ano, G., & Vasconcelles, E. (2005). Religious coping and psychological adjustment to stress: A meta-analysis. *Journal of Clinical Psychology, 61*(4), 461-480.
- Azorin, J. M., Kaladjian, A., Fakra, E., Adida, M., Belzeaux, R., Hantouche, E., & Lancrenon, S. (2013). Religious involvement in major depression: Protective or risky behavior? The relevance of bipolar spectrum. *Journal of Affective Disorders, 150*(3), 753-759.
- Barton, Y., Miller, L., Wickramaratne, P., Gameroff, M., & Weissman, M. (2013). Religious attendance and social adjustment as protective against depression: A 10-year prospective study. *Journal of Affective Disorders, 146*(1), 53-57.
- Budd, F. C. (1999). An Air Force model of psychologist-chaplain collaboration. *Professional Psychology: Research and Practice, 30*, 552-556.
- Budd, F., & Newton, M. (2005). Healing the brokenhearted: Cross and couch together. In M. R. McMinn & A. D. Dominguez (Eds.), *Psychology and the church* (pp. 89-93). Hauppauge, NY: Nova Science.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd edition). Hillsdale, NJ: Erlbaum.

- Conrad, A. K., Jacoby, A. M., Jobes, D. A., Lineberry, T. W., Shea, C. E., Arnold Ewing, T. D., . . . Kung, S. (2009). A Psychometric investigation of the Suicide Status Form II with a psychiatric inpatient sample. *Suicide and Life-Threatening Behavior, 39*(3), 307-320.
- Corona, C., Jobes, D., Nielsen, A., Pedersen, C., Jennings, K., Lento, R., & Brazaitis, K. (2013). Assessing and treating different suicidal states in a Danish outpatient sample. *Archives of Suicide Research, 17*(3), 302-312.
- Delaney, H., Miller, W., Bisonó, A., & Roberts, M. C. (2007). Religiosity and spirituality among psychologists: A survey of clinician members of the American Psychological Association. *Professional Psychology: Research and Practice, 38*(5), 538-546.
- Dervic, K., Oquendo, M. A., Grunebaum, M. F., Ellis, S., Burke, A. K., & Mann, J. J. (2004). Religious affiliation and suicide attempt. (Author Abstract). *American Journal of Psychiatry, 161*(12), 2303.
- Dew, R. E., Daniel, S. S., Goldston, D. B., McCall, W. V., Kuchibhatla, M., Schleifer, C., . . . Koenig, H. G. (2010). A prospective study of religion/spirituality and depressive symptoms among adolescent psychiatric patients. *Journal of Affective Disorders, 120*(1), 149-157.
- Exline, J. J., Pargament, K. I., Grubbs, J. B., Yali, A. M., & Piedmont, R. L. (2014). The Religious and Spiritual Struggles Scale: Development and initial validation. *Psychology of Religion and Spirituality, 6*, 208-222. doi:10.1037/a0036465
- Exline, J. J., & Rose, E. D. (2013). Religious and spiritual struggles. In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (2nd ed.; pp. 380-398). New York, NY: Guilford Press.

- Fisk, L., Flores, M., McMinn, M., Aten, J., Hill, P., Clement Tisdale, T., ... Gathercoal, K. (2013). Spiritual formation among doctoral psychology students in explicitly Christian programs. *Journal of Psychology and Christianity, 32*, 279-290.
- Fremouw, W., Tyner, E., Strunk, J., & Mustek, R. (2005). *Suicidal Adult Assessment protocol—SAAP*. Washington, DC: American Psychological Association.
- Guilfoyle, J., & St Pierre-Hansen, N. (2012). Religion in primary care: Let's talk about it. *Canadian Family Physician Médecin De Famille Canadien, 58*(3), 249-51, e125-7
- Gallup. (2015). Retrieved from <http://www.gallup.com/poll/1690/religion.aspx>
- Harris, K. M., McLean, J. P., Sheffield, J., & Jobes, D. (2010). The internal suicide debate hypothesis: Exploring the life versus death struggle. *Suicide and Life-Threatening Behavior, 40*(2), 181-192.
- Henslee, A., Coffey, S., Schumacher, J., Tracy, M. H., Norris, F., & Galea, S. (2015). Religious coping and psychological and behavioral adjustment after hurricane katrina. *The Journal of Psychology, 149*(6), 630-642.
- Huguelet, P., Mohr, S., Jung, V., Gillieron, C., Brandt, P-Y., & Borrás, L. (2007). Effect of religion on suicide attempts in outpatients with schizophrenia or schizo-affective disorders compared with inpatients with non-psychotic disorders. *European Psychiatry, 22*(3), 188-194.
- Hudson, D., Purnell, L., Duncan, J., & Baker, Q. (2015). Subjective religiosity, church attendance, and depression in the National Survey of American Life. *Journal of Religion and Health, 54*(2), 584-597.
- Hummer, R., Rogers, A., Nam, R., & Ellison, G. (1999). Religious involvement and U.S. adult mortality. *Demography, 36*(2), 273-285.

- Jobes, D. A. (2012). The Collaborative Assessment and Management of Suicidality (CAMS): An evolving evidence-based clinical approach to suicidal risk. *Suicide and Life-Threatening Behavior, 42*(6), 640-653.
- Jobes, D., Jacoby, A., Cimboric, P., & Hustead, L. (1997). The assessment and treatment of suicidal clients in a university counseling center. *Journal of Counseling Psychology, 44*, 368-377.
- Jobes, D., Kahn-Greene, E., Greene, J., & Goeke-Morey, (2009). Clinical improvements of suicidal outpatients: Examining suicide status form responses as predictors and moderators. *Archives of Suicide Research, 13*, 147-159.
- Koenig, H. (2012). Religion, Spirituality, and Health: The Research and Clinical Implications. *International Scholarly Research Network (ISRN) Psychiatry 2012*, 1-33.
doi:10.5402/2012/278730
- Koenig, H., Pargament, K., & Nielsen, J. (1998). Religious coping and health status in medically ill hospitalized older adults. *The Journal of Nervous and Mental Disease, 186*(9), 513-521.
- Lawrence, R. E., Brent, D., Mann, J. J., Burke, A. K., Grunebaum, M. F., Galfalvy, H. C., & Oquendo, M. A. (2016). Religion as a risk factor for suicide attempt and suicide ideation among depressed patients. *The Journal of Nervous and Mental Disease, 204*(11), 845-850. doi:10.1097/nmd.0000000000000484
- Lee, M., Nezu, A., & Nezu, C. (2014). Positive and negative religious coping, depressive symptoms, and quality of life in people with HIV. *Journal of Behavioral Medicine, 37*(5), 921-930.

- Maselko, J., Gilman, S., & Buka, S. (2009). Religious service attendance and spiritual well-being are differentially associated with risk of major depression. *Psychological Medicine, 39*(6), 1009-1017.
- McConnell, K., Pargament, K., Ellison, C., & Flannelly, K. (2006). Examining the links between spiritual struggles and symptoms of psychopathology in a national sample. *Journal of Clinical Psychology, 62*(12), 1469-1484.
- Miller, B. (2015). What really matters at the end of life. *TED: Ideas Worth Spreading*. Retrieved March 10, 2017, from https://www.ted.com/talks/bj_miller_what_really_matters_at_the_end_of_life
- Miller, L., Bansal, R., Wickramaratne, P., Hao, X., Tenke, C., Weissman, M., & Peterson, B. (2014). Neuroanatomical correlates of religiosity and spirituality: A study in adults at high and low familial risk for depression. *JAMA Psychiatry, 71*(2), 128.
- Miller, L., Wickramaratne, P., Gameroff, M., Sage, M., Tenke, C., & Weissman, M. (2012). Religiosity and major depression in adults at high risk: A ten-year prospective study. *The American Journal of Psychiatry, 169*(1), 89-94.
- Newport, F. (2013, April 9). *How religion could lower health costs in America*. Retrieved from [http://www.gallup.com/businessjournal/161669/religion-lower-health-costs-america.aspx?g_source=religion health](http://www.gallup.com/businessjournal/161669/religion-lower-health-costs-america.aspx?g_source=religion%20health)
- Nonnemaker, J. M., McNeely, C. A., & Blum, R. W. (2003). Public and private domains of religiosity and adolescent health risk behaviors: Evidence from the National Longitudinal Study of Adolescent Health. *Social Science & Medicine, 57*(11), 2049-2054.
- Pargament, K. (1997). *The psychology of religion and coping: Theory, research, practice*. New York, NY: Guilford Press.

- Pargament, K., Koenig, H., Tarakeshwar, N., & Hahn, J. (2004). Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: A two-year longitudinal study. *Journal of Health Psychology, 9*(6), 713-30.
- Payman, V., & Ryburn, B. (2010). Religiousness and recovery from inpatient geriatric depression: Findings from the PEJAMA Study. *The Australian and New Zealand Journal of Psychiatry, 44*(6), 560-7.
- Pew Research Center: America's Changing Religious Landscape. (2015). Retrieved from <http://www.pewforum.org/2015/05/12/americas-changing-religious-landscape/>
- Rasic, D. T., Belik, S-L., Elias, B., Katz, L. Y., Enns, M., & Sareen, J. (2009). Spirituality, religion and suicidal behavior in a nationally representative sample. *Journal of Affective Disorders, 114*(1), 32-40.
- Reese, A., Thorpe, M., Bell, R., Bowie, J., & LaVeist, C. (2012). The effect of religious service attendance on race differences in depression: Findings from the EHDIC-SWB Study. *Journal of Urban Health, 89*(3), 510-518.
- Rosmarin, D. H., Bigda-Peyton, J. S., Kertz, S. J., Smith, N., Rauch, S. L., & Björgvinsson, T. (2012). A test of faith in God and treatment: The relationship of belief in God to psychiatric treatment outcomes. *Journal of Affective Disorders, 136* (3), 441-446.
- Rosmarin, D. H., Bigda-Peyton, J. S., Öngur, D., Pargament, K. I., & Björgvinsson, T. (2013). Religious coping among psychotic patients: Relevance to suicidality and treatment outcomes. *Psychiatry Research, 210*(1), 182-187.
- Schettino, J., Olmos, N., Myers, H., Joseph, N., Poland, R., & Lesser, I. (2011). Religiosity and treatment response to antidepressant medication: A prospective multi-site clinical trial. *Mental Health, Religion & Culture, 14*(8), 805-818.

- Schottenbauer, M., Rodriguez, B., Glass, C., & Arnkoff, D. (2006). Religious coping research and contemporary personality theory: An exploration of Endler's (1997) integrative personality theory. *British Journal of Psychology, 97*(4), 499-519.
- Shafranske, E. P., & Malony, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy, 27*, 72-78
- Smith, T., McCullough, M., Poll, J., & Cooper, Harris. (2003). Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin, 129*(4), 614-636.
- Stratta, P., Capanna, C., Riccardi, I., Carmassi, C., Piccinni, A., Dell'Osso, L., & Rossi, A. (2011). Suicidal intention and negative spiritual coping one year after the earthquake of L'Aquila (Italy). *Journal of Affective Disorders, 136*(3), 1227-1231.
- Svob, C., Reich, L., Warner, V., & Weissman, M. (2016). Religion and spirituality predict lower rates of suicide attempts and ideation in children and adolescents at risk for major depressive disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 55*(10S), 251-251. Retrieved from www.jaacap.org.
- Terreri, C., & Glenwick, J. (2013). The relationship of religious and general coping to psychological adjustment and distress in urban adolescents. *Journal of Religion and Health, 52*(4), 1188-1202.
- Trevino, K. M., Balboni, M., Zollfrank, A., Balboni, T., & Prigerson, H. G. (2014). Negative religious coping as a correlate of suicidal ideation in patients with advanced cancer. *Psycho-Oncology, 23*(8), 936-945.
- United States Census Bureau: Yamhill County, Oregon (2015). Retrieved from <https://www.census.gov/quickfacts/table/PST045215/41071>

World Health Organization: Suicide data. (2012). Retrieved from

http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/

Wu, A., Wang, J., Jia, C., & Mazza, M. (2015). Religion and completed suicide: A meta-analysis. *Meta-Analysis of Religion and Suicide*, 10(6), E0131715.

Yangarber-Hicks, N. (2004). Religious coping styles and recovery from serious mental illnesses. *Journal of Psychology and Theology*, 32(4), 305.

Zhang, J., Xiao, S., & Zhou, L. (2010). Mental disorders and suicide among young rural Chinese: A case-control psychological autopsy study. *The American Journal of Psychiatry*, 167(7), 773-81.

Zinnbauer, B. J., Pargament, K. I., Cole, B., Rye, M. S., Butter, E. M., Belavich, T. G., . . .

Kadar, J. L. (1997). Religion and spirituality: Unfuzzifying the fuzzy. *The Journal for the Scientific Study of Religion*, 36(4), 549.

Zuckerman, M., Silberman, J., & Hall, J. A. (2013). The Relation between intelligence and religiosity: A meta-analysis and some proposed explanations. *Personality and Social Psychology Review*, 17 (4), pp.325-354. <https://doi.org/10.1177/1088868313497266>

Appendix A

CAMS Suicide Status Form-SSF IV (Initial Session)

Patient Name: _____ DOB: _____

Date: _____ Time: _____

Section A (Patient):

Rate and fill out each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind, not stress, not physical pain) Low pain: 1 2 3 4 5 6 7 8 9 10 : High pain

What I find most painful is: _____

2) RATE STRESS (your general feeling of being pressured or overwhelmed):

Low stress: 1 2 3 4 5 6 7 8 9 10 : High stress

What I find most stressful is: _____

3) RATE AGITATION (emotional urgency: feeling that you need to take action: not irritation; not annoyance):

Low agitation: 1 2 3 4 5 6 7 8 9 10 : High agitation

I most need to take action when: _____

4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do):

Low hopelessness: 1 2 3 4 5 6 7 8 9 10 : High hopelessness

I am most hopeless about: _____

5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect):

Low self-hate: 1 2 3 4 5 6 7 8 9 10 : High self-hate

What I hate most about myself is: _____

RATE OVERALL RISK OF SUICIDE:

Extremely low risk (will not kill self): 1 2 3 4 5 6 7 8 9 10 : Extremely high risk (will kill self)

1) How much is being suicidal related to thoughts and feelings about yourself?

Not at all: 1 2 3 4 5 6 7 8 9 10: completely

2) How much is being suicidal related to thoughts and feelings about others?

Not at all: 1 2 3 4 5 6 7 8 9 10: completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

REASONS FOR LIVING:

REASONS FOR DYING:

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 9 10 :Very much
I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 9 10 :Very much
The one thing that would help me no longer feel suicidal would be: _____

Appendix B**Curriculum Vitae****ROSANNA J.S. Bailey**

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 269-615-5385 | rosanna.shoup@gmail.com

EDUCATION

Doctoral Student of Psychology, Clinical Psychology George Fox University, Newberg, Oregon	Sept. 2013-Present
Masters of Arts, Clinical Psychology	May 2015
Doctor of Clinical Psychology	Expected: 2018
Bachelor of Arts, Psychology and Religion Kalamazoo College, Kalamazoo, Michigan Cum Laude	Sept. 2007-Jun.. 2011

AWARDS

Kalamazoo College Senior Leadership Award	Jan. 2011
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SUPERVISED CLINICAL EXPERIENCE

Practicum II/ Pre-Internship Oregon Health and Science University: Family Medicine at Scappoose <i>Hours:</i> 16-20hrs a week <i>Populations Served:</i> Rural population of Columbia County <i>Duties:</i> Conduct long term and short term therapy for individuals, engage in consultation with primary care providers and aides, assist in on-site mental health support, conduct research for implementation of telemental health <i>Modality:</i> CBT, ACT, & Motivational Interviewing <i>Supervisors:</i> Joan Fleishman, PsyD. & Chole Ackerman, PsyD.	Aug. 2015-Present
Supplemental Practicum Behavioral Health Crisis Consultant for Yamhill County <i>Hours:</i> 12-15 hour shifts; 2-4 shifts a month <i>Populations Served:</i> High risk patients for Providence Medical Group Hospital and Willamette Valley Medical Center	Apr. 2015-Present

Duties: Conduct risk assessments for suicide, psychosis, and other impairment. Emergency/ ICU departments. Risk assessments:: Risk/Protective Factors and Warning Signs (SAP), Collaborative Assessment and Management of Suicidality (CAMS), Montreal Cognitive Assessment (MoCa)
Supervisors: Mary Peterson, PhD., Joel Gregor, PsyD., William Buhrow, PsyD., & Luann Foster, PsyD.

Supplemental Practicum

May 2016-Oct. 2016

Oregon State University: Assessment Assistant

Hours: Approximately 20 hours total

Populations Served: Male and female college undergraduate athletes in high impact sports including football, baseball, gymnastics, volleyball, rowing, and others.

Duties: Conducted group evaluations for academic skills, personality testing, and executive functioning. Conducted individual testing for memory skills, effort, executive functioning. Data gathered baseline information to compare to post head injury performance on evaluation.

Supervisor: Robert Fallows, PsyD.

Practicum I

Oct. 2014-Aug. 2016

George Fox Behavioral Health Clinic

Hours: 16 hours a week

Populations Served: Underserved population in Yamhill County

Duties: Provided community mental health outpatient treatment for individuals of all ages and families; Conducted Chronic Pain group and a Christian faith process group on CBT. Lead Didactics on Solution Focused Brief Psychotherapy and Sexual Addiction

Modality: CBT, Solution Focused Behavioral Therapy

Supervisors: Chloe Ackerman, M.A., Tina Kang, M.A., & Joel Gregor, PsyD

Pre-Practicum

Jan. 2014 - May 2014

George Fox University, PsyD Dept.

Hours: 5 hours a week

Populations Served: Two pre-selected college students

Duties: Therapist for two college students

Modality: Person Centered

Supervisors: Carlos Taloyo, Ph.D., & Trinity Parker, M.A

Clinical Team

Sept. 2013-Present

George Fox University, PsyD. Dept.

Hours: 1.5 hours a week

Duties: Case consultation and review

Modality: CBT, ACT, Psychodynamic, Person-centered

Supervisors: Ericka Tan, PsyD., Mary Peterson, PhD. ABPP, Nancy Thurston, PhD. ABPP, & Celeste Flachesbart, PsyD. ABPP

PREVIOUS EMPLOYMENT

Lead Field Instructor

New Vision Wilderness: Therapeutic Outdoor Program

Hours: 8 days in field camping 24/7 and 6 days off

Population Served: Adolescents and young adults; Clients presenting problems related to one or more of the following: trauma, attachment, depression, ODD, substance use, etc.

Duties: Monitored safety and well being of clients; conducted groups on psycho-education, leadership and communication; participated in a multidisciplinary team; provided behavioral interventions; organized daily structure; coordinated logistics; Assisted in searches, restraints, and crisis interventions with team for high risk behaviors

Supervisor: Joe Collins, B.S., Operations Director

Jun. 2011-May 2012;

Oct. 2012-Jul. 2013

Office Intern for LandSea

LandSea Outdoor Program, Kalamazoo College

Hours: Approx. 10-15 hours a week

Population: Students and staff of Kalamazoo College

Duties: Assisted with the office duties; processed participant applications; ordered gear; scheduled meetings; analyzed feedback from leaders, participants, and program facilitators

Supervisor: Ty Manegold, B.A.

Feb. 2010-Jun. 2011

Certified Nursing Assistant

North Mahaska Nursing and Rehab

Hours: Dec. & Jan. 24-40 hours a week; Jun.-Aug. PRN

Population Served: Geriatric residents with health, mobility, or cognitive decline

Duties: Assisted elderly residents with skills of daily living; systems environment; coordinate needs and logistics; Basic medical training (vitals, medical asepsis, peri care)

Supervisor: Jacqueline Garden, R.N. Director of Nursing

Jul. 2007- Mar. 2009

Wilderness Leader

LandSea Outdoor Program, Kalamazoo College

Hours: Two month summer wilderness training & expedition

Jul. 2008- Sept.2008

Population: College freshman students

Duties: Monitored safety of a 'patrol' of eleven participants; taught wilderness skills including navigation, food & animal safety, facilitated team-building; led daily group processing

Supervisor: Ty Manegold, B.A.

RESEARCH EXPERIENCE

Dissertation Title: Religious Coping and Spiritual Struggle among Emergency Room Patients with Suicidal Intent

Chair: Mark McMinn, PhD , ABPP

Committee: Kathleen Gathercoal, PhD & Mary Peterson, PhD

Pre Lim: Jun. 2016

Expected: Jun. 2017

Research: Program Development for Tele-mental health at OHSU: Family Medicine Scappoose; Review literature for telemental health including treatment for health / mental health conditions, billing/reimbursement, proper equipment, laws and ethical guidelines for practicing tele-mental in Oregon.

Jun.. 2016-Present

McMinn, M. R., McLaughlin, P. T., Johnson, B. C., & Shoup, R. (2016). Psychotherapy and the Theological Virtues. *Open Theology*, 2(1). doi:10.1515/opth-2016-0035

Mar. 2016

Geczy-Haskins, L.A., Shoup, R.S., McMinn, M.R., & Goetsch, B.L. (2015, August). *Reported and Actual Compliance in a Psychology of Religion Experiment*. Poster session presented at APA conference 2015 Division 36, The Society for the Psychology of Religion and Spirituality, 122nd annual convention, APAGS, Toronto, ON

Aug. 2015

Research Vertical Team

Topic: Spiritual and Religious dissertation group; collaborative team support for research and ideas

Advisor: Mark McMinn, PhD., ABPP

Feb. 2012-Present

Smith, C., Lowen, J., Oliver, H., ...(2012, August). Predictors of success in a graduate clinical psychology program. Poster session presented at APA conference 2012 American Psychology of Association of Graduate Students, Orlando, FL.

Aug. 2012

Gosling, S., Graham, L., & Shoup, R. (2011) Good Vibes: Evaluating the 'ambiance' elicited from public spaces. Poster session presented at Society of Experiment and Social Psychology Conference, San Antonio, TX.

Jan. 2011

Senior Individualized Project Kalamazoo College; University of Texas, Austin, TX Good Vibes: Evaluating 'ambiance' elicited from public spaces <i>With Researchers:</i> Sam Gosling, PhD., & Lindsay Graham, B.A.	Nov. 2010
Research Assistant Psychology Dept., Kalamazoo College <i>Topic:</i> Family dynamics in Middle Eastern cultures <i>Researcher:</i> Gary Gregg, Ph.D	Jan. 2008-May 2008

TEACHING AND LEADERSHIP

Teacher's Assistant: History and Systems Faculty: Kathleen Gathercoal, PhD.	Sept 2016-Present
Provided Lecture for History and Systems	Sept. 2016
Student Representative and Application reviewer for Admissions Committee at George Fox University, PsyD. Dept.	Sept. 2015-Feb. 2016
Teacher's Assistant: Ethics Faculty: Roger Bufford, PhD.	Sept. 2015-Dec. 2015
Training and Awareness Liaison for Multicultural Committee	Sept. 2015-Dec. 2015
Campus Representative for Division 35: Psychology of Women	Aug. 2015-Jun.. 2015
Campus Representative for American Psychology Association of Graduate Students (APAGS)	Aug. 2015-Jun.. 2015
Member of the Oregon Psychology Association Legislative Committee	Sept. 2015-Jun.e 2015
Student member of Community Worship committee	Sept. 2013-Present
Student Chaplain for Kalamazoo College Interfaith Chapel	Jun.. 2009- Jun.. 2011

GRADUATE COURSEWORK

Psychopharmacology George Fox University, PsyD Dept. Faculty: Glenna Andrews, PhD	Jan. 2017-Present
Supervision and Management	Sept. 2016-Present

George Fox University, PsyD Dept.
Faculty: Roger Bufford, PhD

Professional Issues

George Fox University, PsyD Dept.
Faculty: Glenna Andrews, PhD

Sept. 2016-Dec. 2016

Neuropsychology

George Fox University, PsyD Dept.
Faculty: Glenna Andrews, PhD

Jan. 2016-Apr. 2016

Biological Basis of Psychology

George Fox University, PsyD Dept.
Faculty: Celeste Flachesbart, PsyD, ABPP

Sept. 2015-Dec. 2015

Object Relations and Relational Psychoanalysis

George Fox University, PsyD Dept.
Faculty: Nancy Thurston, PsyD, ABPP

Sept. 2015-Dec. 2015

Health Psychology

George Fox University, PsyD Dept.
Faculty: Jeri Turgesen, PsyD

Jun.. 2015-Aug. 2015

Acceptance and Commitment Therapy

George Fox University, PsyD Dept.
Faculty: Brian Goff, PhD

Jun.. 2015-Aug. 2015

Psychodynamic Therapy

George Fox University, PsyD Dept.
Faculty: Nancy Thurston, PsyD, ABPP

Jan. 2015-Apr. 2015

Research Design

George Fox University, PsyD Dept.
Faculty: Kathleen Gathercoal, PhD

Jan. 2015-Apr. 2015

Cognitive Assessment Sept 2014-Dec. 2014

George Fox University, PsyD Dept.
Faculty: Celeste Flachsbart, PsyD

Sept. 2014-Dec. 2014

Cognitive Behavioral Therapy

George Fox University, PsyD Dept.
Faculty: Mark McMinn, PhD, ABPP

Sept. 2014-Dec. 2014

History and Systems of Psychology Sept 2014-Dec. 2014

George Fox University, PsyD Dept.

Sept. 2014-Dec. 2014

Faculty: Kathleen Gathercoal, PhD

Social Psychology Jun.. 2014- Jul. 2014
George Fox University, PsyD Dept.
Faculty: Joel Gregor, PsyD

Special Study: Feminist Therapy
George Fox University, PsyD Dept.
Faculty: Carlos Taloyo, PhD Jun. 2014- Jul. 2014

Learning, Emotion, and Cognition May 2014-Jun. 2014 Jun. 2014- Jul. 2014
George Fox University, PsyD Dept.
Faculty: Marie-Christine Goodworth, PhD

Family and Couples Therapy Jan. 2014-May 2014
George Fox University, PsyD Dept.
Faculty: Mary Peterson, PhD, ABPP

Integrative Approaches to Psychotherapy Jan. 2014-May 2014
George Fox University, PsyD Dept.
Faculty: Rodger Bufford, PhD

Clinical Foundations for Treatment II Jan. 2014-May 2014
George Fox University, PsyD Dept.
Faculty: Carlos Taloyo, PhD

Personality Assessment Jan. 2014-May 2014
George Fox University, PsyD Dept.
Faculty: Paul Stoltzfus, PsyD

Theories of Personality and Psychotherapy Jan. 2014 - May 2014
George Fox University, PsyD Dept.
Faculty: Winston Seegobin, PsyD

Clinical Foundations for Treatment I Sept. 2013- Dec. 2013
George Fox University, PsyD. Dept.
Faculty: Carlos Taloyo, PhD

Ethics for Psychologists Sept. 2013- Dec. 2013
George Fox University, PsyD. Dept.
Faculty: Rodger Bufford, PhD

Human Development Sept. 2013- Dec. 2013
George Fox University, PsyD. Dept.
Faculty: Elizabeth Hamilton, PhD

Psychopathology Sept. 2013- Dec. 2013
 George Fox University, PsyD. Dept.
 Faculty: Jeri Turgesen, PsyD

PROFESSIONAL DEVELOPMENT

Supervision of Student Sept. 2016-Present
 PsyD. Dept., George Fox University
Hours: 1.5 hours weekly
 Population: One Second year Student
 Duties: Provided Supervision to a Second year student,
 assisting with case consultation, assessment skills, review
 of ethical procedures, and building awareness for
 multicultural and contextual factors
Supervisors: Dr. Celeste Flachesbart, PsyD.

Collaborative Family and Healthcare Association: 2016
 Charlotte, NC

Association for Contextuabl Behavioral Science World 2016
 Conference 14
 Seattle, WA

Acceptance and Commitment Therapy Bootcamp 2016
 Marin, California
Hours: 35 hours
Presenters: Robyn Walser, PhD., Kelly Wilson, PhD.,
 Steve Hayes, PhD., Benji Schoendorff, MA, MSc & Marie-
 France Bolduc, MPs

From Isolation to Belonging: 2016
Using ACT and Affective Science to Deepen Your Work
with Clients Stuck in Self-Criticism and Shame
 Association for Contextual Behavioral Science World
 Conference, Pre Conference Workshop
 Seattle, WA
Hours: 16 hours
Presenters: Jason Luoma, Ph.D., Jenna LeJeune, Ph.D., &
 Melissa Platt, Ph.D.

Meaningful Care Conference: LGBTQI Healthcare 2016
 Portland, OR

Managing with Diverse Clients 2016

George Fox University, Newberg, OR
Sandra Jenkins, PhD

Neuropsychology: What Do We Know 15 Years After the
Decade of the Brain? And Okay, Enough Small Talk. Let's
Get Down to Business

George Fox University, Newberg, OR

Trevor Hall PsyD and Darren Janzen, PsyD

2016

Let's Talk about Sex: sex and sexuality with clinical
application

2015

George Fox University, Newberg, OR

Joy Mauldin PsyD

Collaborative Family and Healthcare Association

2015

Relational Psychoanalysis and Christian Faith: A Heuristic
Dialogue

2015

George Fox University, Newberg, OR

Marie Hoffman, PhD

Spirituality Formation and Psychotherapy

2015

George Fox University, Newberg, OR

Barrett McRay, PsyD

Credentialing, Banking, the Internship Crisis, and other
Challenges for Graduate Students in Psychology

2015

George Fox University, Newberg, OR

Morgan Sammons, PhD., ABPP

Annual Northwest Psychological Assessment Conference

2014

George Fox University, Newberg, OR

Evidenced Based Treatments for PTSD in Veteran
Populations: Clinical and Integrative Perspectives

2014

George Fox University, Newberg, OR

David Beil-Adaskin, PsyD

"Facetime" in an Age of Technological Attachment

2014

George Fox University, Newberg, OR

Full day training session

Doreen Dodgen-Magee, PsyD

ACT for Chronic Pain: understanding chronic pain from a
contextual behavioral approach

2014

Portland, OR
The Lifequal Center
 Full Day Training
 Kevin Vowles

ADHD: Evidence-based practice for children and adolescents 2014
George Fox University, Newberg, OR
 Erika Doty, PsyD, and Tabitha Becker, PsyD

DSM-V 2014
George Fox University, Newberg, OR
 Half day training session
 Jeri Turgesen, PsyD, and Mary Peterson, PhD

Integrated Primary Care 2013
George Fox University, Newberg, OR
 Full day training session
 Brian Sandoval, PsyD, and Juliette Cutts, PsyD

ASSESSMENT EXPERIENCE

16 Personality Factor Questionnaire
 Adaptive Behavioral Assessment System- III
 Alcohol Use Disorders Identification Test
 Behavior Assessment System for Children- II and III
 Behavior Rating Inventor of Executive Function
 Brown ADD Adult Scale
 California Verbal Learning Test- II
 Conners- III Edition
 Conners Continuous Performance Test-III
 Conners Kiddie Continuous Performance Test-II
 Collaborative Assessment and Management of Suicidality
 Delis-Kaplan Executive Function System
 Drug Abuse Screening Test
 Generalized Anxiety Disorder- 7
 Mini Mental State Exam
 Minnesota Multiphasic Personality Inventory- II & Restructured Form
 Minnesota Multiphasic Personality Inventory-Adolescent
 NEPSY-II
 Patient Health Questionnaire 9
 Personality Assessment Inventory

Personality Assessment Inventory-Adolescent
 Roberts 2nd Edition
 Rey-Osterrieth Complex Figure
 Screening Brief Intervention Referral to Treatment
 Test of Memory and Malinger
 Wechsler Abbreviated Scale of Intelligence-II
 Wechsler Adult Intelligence Scale-IV
 Wechsler Memory Scale-IV
 Wechsler Individual Achievement Test –III
 Wechsler Intelligence Scale for Children-IV & V
 Wide Range Achievement Test-IV
 Wide Range Assessment of Memory and Learning-II
 Wisconsin Card Sort
 Wide Range Assessment of Memory and Learning-2
 Woodcock Johnson-IV Tests of Cognitive Ability
 Woodcock Johnson-IV Tests of Achievement
 Vanderbilt Assessment Scale

Memberships

Collaborative Family Healthcare Association	2015-Present
APA Division 35, Psychology of Women	2014-Present
American Psychological Association, Student Affiliate	2013-Present
George Fox University Multicultural Committee of Clinical Psychology	2013-Present
George Fox University Gender and Sexuality Committee of Clinical Psychology	2013-2015

References

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 Portland, OR