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Brief Report

Psychometric Properties of the Clergy Suicide Prevention Competencies Developmental Rubric and Faith Leaders' Readiness to Address Suicide Stigma

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Abstract: Faith leaders (FL) have a key role in suicide prevention. One of their roles is to address suicide stigma in faith communities. Are they ready to do so? The Clergy Suicide Prevention Skills Developmental Rubric (CSPCDR) was developed to understand and assess clergy suicide prevention skills. The psychometric properties of the CSPCDR are reported in order to assess FL' readiness to address suicide stigma. Sample 1, 186 Protestant seminary students completed the CSPCDR twice, resulting in Pearson's $r = 0.77$. Sample 2, 187 Protestant clergy and lay ministers completed the CSPCDR before and after one of eight trainings to test construct validity; the CSPCDR performed as expected. Results suggest how to expand FL' readiness to address suicide stigma in faith communities.

Keywords: suicide; stigma; faith leaders; psychometric properties; developmental rubric

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1. Introduction

The 2012 National Strategy for Suicide Prevention (HHS 2012) emphasizes the importance of infusing suicide prevention into a broad range of organizations, including faith-based organizations, in order to address suicide stigma (p. 30). Faith leaders (FL) "play a key role in . . . preventing the tragedy of suicide" using a set of competencies which includes "reducing negative stereotypes" (National Action Alliance for Suicide Prevention: Faith Communities Task Force 2019, pp. 3, 10). One of FL' roles is to address suicide stigma in faith communities (FC). However, doing so requires many skills, such as reflecting theologically about suicide, preaching, teaching about people of faith having difficulties (including suicidal behaviors), and fostering FC where people touched by suicide can reach out for help and FC can minister to them (Mason 2021). To address stigma, FL must develop a multiplicity of skills. It is not clear that FL have these skills and are ready to address suicide stigma in FC. This study will report on the psychometric properties of the Clergy Suicide Prevention Skills Developmental Rubric (CSPCDR) and on FL' readiness to address suicide stigma in FC.

In order to understand FL' suicide prevention skills, the CSPCDR was developed through grounded theory (Mason et al. 2019) and literature review (Mason et al. 2020). An instrument is said to have content validity if all the aspects of a construct are represented in the measure. This type of validity is particularly important in occupational skills tests (Borg and Gall 1989). Grounded theory relies on the consensus of experts (Creswell 2007). A purposive sample of 19 U.S. Protestant clergy who had engaged suicide in their FC completed interviews until saturation. Constant comparative data analysis and member-checking in an online focus group with 10 participants, who were deemed experts, and working at the inspiring developmental stage resulted in 10 competencies, expanded to fifteen through literature reviews (Mason et al. 2021; Marshall 2005).

The CSPCDR is a 15-item developmental rubric (Appendix A). While other questionnaires measure only attitudes toward suicide (e.g., the General Social Survey, Davis and Smith 1980, the Suicide Opinion Questionnaire, and Domino et al. 1982), the CSPCDR assesses fifteen suicide prevention skills (attitudes about suicide, culture, theological reflection, community building, preaching/teaching to protect against suicide, knowing your role, listening, confidence, safety planning, referral, ministering to survivors, conducting memorial services or memorial ceremonies, managing contagion and clusters, self-care, and guilt). For each skill, the respondent selects their level of development over four stages (beginning, fundamental, practical, and inspiring) by choosing the key phrase that best describes them. While the developmental rubric is essential to the development of FL training, understanding the psychometric properties of the CSPCDR would allow for an assessment of FL' readiness to address suicide stigma in their FC.

The research questions that shaped this exploratory study were: (1) does the CSPCDR consistently and accurately measure the suicide prevention skills of FL and (2) based on the CSPCDR, are FL ready to address suicide stigma in their FC? Stigma is defined as relational status markers that reduce a stigma holder "from a whole and usual person to a tainted and discounted one" (Goffman 1963, p. 3). FL are defined as leaders who are recognized by FC to provide both formal and informal spiritual guidance and assistance to congregants. FL can include clergy who are ordained to their role or lay leaders who are not ordained. FC are gatherings of congregants focused on religion or spirituality.

2. Method

2.1. Participants and Procedures

The Gordon-Conwell Theological Seminary Institutional Review Board approved the study on 2 October 2018. Participants were all Protestant FL (clergy or lay leaders). Homogeneous convenience samples, such as Protestant FL, can be considered to have scientific merit (Jager et al. 2017). After being given all relevant information, each participant provided consent prior to participating.

2.1.1. Reliability

For reliability studies, guidelines recommend a minimum sample size of five respondents for each instrument item (Tsang et al. 2017, p. 12), though larger sample sizes are preferred. To test reliability, Sample 1, a convenience sample of 186 seminary students (a ratio of 12.4 participants to each of 15 items) from two campuses (n = 79 from the urban and n = 107 from the suburban campus) at a Protestant northeastern seminary completed the CSPCDR in classes twice. Test and retest administrations were matched for each participant with a four- to five-week interval between administrations, deemed to be long enough for participants to forget their responses, while not allowing other factors (e.g., learning) to change their responses. The seminary curriculum did not include a course in suicide prevention during the test–retest time lapse. Reliability tests (Table 1) included internal consistency reliability and test-retest reliability using Pearson's r, canonical correlation, Inter-Item Correlation Coefficients (ICC), paired t-tests, and repeated measures ANOVA. Level of significance was set at 0.01 to control for Type I errors. A correlation $\geq$ 0.70 is interpreted as "excellent" and an ICC close to 1 suggests that a given measurement reflects the true value of that measurement and a greater capacity to detect real differences between participants (Borges et al. 2018).

2.1.2. Validity

To test validity, Sample 2, a convenience sample of 187 Protestant FL, completed the CSPCDR twice, before and after a suicide prevention training (a ratio of 12.47 participants to each of 15 items). Sample 1 functioned as a control group to Sample 2, the intervention group, which received suicide prevention training. They participated in one of eight trainings of different durations, which were developed based on 15 skills generated by grounded theory and literature review. Because the organizers of the eight trainings

expressed interest in trainings of different lengths and in different content, the skills included in the trainings differed by sample, though all eight covered *Theological Reflection* and *Managing Contagion and Clusters*; Protestant clergy have reported they need "theological grounding to discuss/explain suicide" (Mason et al. 2021, p. 87), they hold a range of nuanced views on suicide (Mason et al. 2011) and they do not know how to manage contagion and clusters (Mason et al. 2020).

Construct validity (Cronbach and Meehl 1955) is the extent to which an instrument reflects a particular construct where proposed interpretations generate "specific testable hypotheses" (p. 290), such as expected "group differences" (Cronbach and Meehl 1955, p. 287). It was expected that Time 2 self-ratings would be significantly higher for Sample 2 than for Sample 1 (which did not receive training). Construct validity can also suggest the testable hypothesis of "change over occasions" (p. 288). It was expected that post-training ratings would be significantly higher than pre-training ratings in Sample 2.

2.1.3. Readiness

Skills for addressing suicide stigma in FC, as identified by Mason (2021), were compared to the Sample 2 CSPCDR post-training means to determine readiness to address suicide stigma. As outlined elsewhere (Mason et al. 2019), the developmental rubric theory suggests that the beginning stage (a mean between 1.0 and 1.99) describes strategies FL use when they first engage suicide in the FC. The fundamental stage (a mean between 2.0 and 2.99) describes strategies FL use after the first encounters are behind them; these fundamental strategies work temporarily, but do not work long-term. For example, FL may give up their day off to attend to congregant needs but would not be able to sustain that strategy long-term. The practical stage (a mean between 3.0 and 3.99) is the final developmental stage for many FL because at this level they have developed effective suicide prevention skills. Some FL do not progress to the final inspiring stage (a mean between 4.0 and 4.99), where the influence of FL is beyond their local FC. Therefore, readiness in this study is defined as being at the practical stage (a mean between 3.0 and 3.99).

3. Results

3.1. Reliability

Reliability is summarized in Table 1.

Table 1. Reliability statistics.

Time 1 (test) internal consistency	Cronbach's $\alpha = 0.84$
Time 2 (retest) internal consistency	Cronbach's $\alpha = 0.89$
Test–retest reliability	Pearson's $r = 0.77$ (with the assumptions of a linear relationship and normality met)
Canonical correlation finds the linear combinations of Time 1 and Time 2, which have maximum correlation with each other.	Canonical correlations ranged from 0.93 to 0.04; the first canonical correlation being significant (Wilks' lambda $F(225, 501.77) = 2.54$, $p < 0.0000$ **).
Intra-class correlations by respondent	0.77
Intra-class correlations by respondent over time	0.77
Paired sample *t*-tests of the mean values of self-ratings at Time 1 and Time 2	Means at Time 1 ($M = 34.46$, $SD = 8.65$) and Time 2 ($M = 34.34$, $SD = 9.24$) were not significantly different $t(132) = 0.21$, $p = 0.83$.
A repeated-measures ANOVA assessed test–retest reliability while accounting for respondent and time (Borges et al. 2018).	While respondents differed significantly ($F(185) = 6.68$, $p < 0.0000$ **), the model and the respondent-by-time interaction were not significant.

** $p < 0.01$.

3.2. Validity

Reliability statistics were similar or better for Sample 2 (Time 1 Cronbach's $\alpha = 0.85$, Time 2 Cronbach's $\alpha = 0.88$, Pearson's $r = 0.93$, first canonical correlation 0.85, Wilks' lambda $F = 1.45$, $p = 0.0007$ **, ICC by respondent was 0.83, and by respondent over time was 0.84). Table 2 summarizes results of construct validity tests.

Table 2. Construct validity tests.

Description of Sample	Change over Occasions (Comparison of Pre- and Post-Training Means)	Group Differences (Comparison of Sample 1 and Sample 2 Change Means)
Sample 1 and Sample 2		Sample 1 change from Time 1 to Time 2: $M = -0.11$ ($SD = 6.13$) Sample 2 change from Time 1 to Time 2: 7.13 ($SD = 6.47$) Comparison between sample change means: $F(1) = 100.73$, $p < 0.0000$ **
Sample A 18 ministerial and counseling students 30 h All 15 skills	Pre-training CSPCDR $M = 34.14$ ($SD = 6.54$) Post-training CSPCDR $M = 47.47$ ($SD = 6.67$) Change: $M = 13.33$ ($SD = 6.54$) Comparison between pre- and post-training means: $t(17) = -8.64$, $p < 0.0000$ **	
Sample B Five clergy 1 h Theological reflection Preaching/teaching to protect against suicide Safety planning Managing contagion and clusters	Pre-training on 4 skills $M = 9.60$ ($SD = 2.70$) Post-training on 4 skills $M = 12.2$ ($SD = 2.95$) Change: $M = 2.60$ ($SD = 2.41$) Comparison between pre- and post-training means: $t(4) = -2.41$, $p = 0.07$	
Sample C 84 clergy and lay ministers 3 h Theological reflection Preaching/teaching to protect against suicide Managing contagion and clusters Conducting memorial services or memorial ceremonies	Pre-training on 4 skills $M = 9.28$ ($SD = 2.61$) Post-training on 4 skills $M = 13.22$ ($SD = 2.59$) Change: $M = 3.94$ ($SD = 2.74$) Comparison between pre- and post-training means: $t(83) = -13.18$, $p < 0.0000$ **	
Sample D 10 clergy and lay ministers 1 h Theological reflection Safety planning Managing contagion and clusters	Pre-training on CSPCDR $M = 33.80$ ($SD = 7.05$) Post-training on CSPCDR $M = 42.80$ ($SD = 9.56$) Change: $M = 9$ ($SD = 7.27$) Comparison between pre- and post-training means: $t(9) = -3.91$, $p = 0.004$ **	

Table 2. *Cont.*

Description of Sample	Change over Occasions (Comparison of Pre- and Post-Training Means)	Group Differences (Comparison of Sample 1 and Sample 2 Change Means)
Sample E 17 clergy and lay ministers 1 h Theological reflection Safety planning Managing contagion and clusters	Pre-training CSPCDR M = 35.12 (SD = 7.46) Post-training CSPCDR M = 44.59 (SD = 7.15) Change: M = 9.47 (SD = 5.51) Comparison between pre- and post-training means: $t(16) = -7.08$, $p < 0.0000$ **	
Sample F 16 clergy and lay ministers 6 h Theological reflection Preaching/teaching to protect against suicide Safety planning Ministering to survivors Managing contagion and clusters Conducting memorial services or memorial ceremonies [15 min discussion on culture in answer to participant question]	Pre-training CSPCDR M = 34.77 (SD = 8.19) Post-training CSPCDR M = 46.77 (SD = 7.37) Change: M = 12 (SD = 9.25) Comparison between pre- and post-training means: $t(12) = -4.68$, $p = 0.0005$ **	
Sample G 19 clergy 2 h Theological reflection Preaching/teaching to protect against suicide Safety planning Managing contagion and clusters Conducting memorial services or memorial ceremonies	Pre-training CSPCDR M = 40.17 (SD = 7.21) Post-training CSPCDR M = 44.72 (SD = 7.34) Change: M = 4.56 (SD = 5.25) Comparison between pre- and post-training means: $t(17) = -3.68$, $p = 0.002$ **	
Sample H 18 ministerial and counseling students 18 h online All 15 skills	Pre-training CSPCDR M = 37.06 (SD = 8.61) Post-training CSPCDR M = 49.89 (SD = 5.31) Change: M = 12.83 (SD = 7.67) Comparison between pre- and post-training means: $t(17) = -7.1$, $p < 0.0000$ **	

** $p < 0.01$.

On average, Sample 2 participants' ratings changed by 7.13 (SD = 6.47) developmental rating units across 15 skills, a significant difference from Sample 1 participants' change from Time 1 to Time 2 ($M = -0.11$, SD = 6.13, $F(1) = 100.73$, $p < 0.0000$ **). Sample 2, the intervention group, which received suicide prevention training, reported a significant change in their skills compared to Sample 1, the control group which received no training. This finding lends support to the construct validity of the CSPCDR in that Sample 2 change differed significantly from Sample 1 change. On the two skills included in all eight Sample 2 trainings (*Theological Reflection* and *Managing Contagion and Clusters*), mean change for Sample 1 (M = 0.11, SD = 1.18) was significantly different from the mean change for Sample 2 (M = 2.31, SD = 1.62) ($F(1) = 154.84$, $p < 0.0000$ **).

Sample 2 self-ratings changed significantly from pre-training ratings (M = 23.06, SD = 14.62) to post-training-ratings (M = 30.18, SD = 17.49) ($t(182) = -14.9$, $p < 0.0000$ **), except in Sample B, due to a small sample size of five participants. When the means of the

two skills included in all eight trainings (*Theological Reflection* and *Managing Contagion and Clusters*) were added, the pre-training mean (M = 4.35, SD = 1.58) was significantly different from the post-training mean (M = 6.67, SD = 1.16) ($t(169) = -18.66$, $p < 0.0000$ **). The largest mean change was for *Managing Contagion and Clusters* (M = 1.53, SD = 0.99). Sample 2's eight training samples (A-H) differed significantly in overall change ($F(7) = 14.44$, $p < 0.0000$ **), favoring longer trainings.

The overall change does not capture that each sample began and ended the trainings at different developmental levels. For example, on the two skills included in all eight trainings (*Theological Reflection* and *Managing Contagion and Clusters*), Sample C's mean change was 2.26 developmental units, less than Sample E's mean change of 2.53 units. However, Sample C's post-training mean was 6.95, more than Sample E's post-training mean of 6.21. Sample E reported more change, but Sample C started (M = 4.69) and ended (M = 6.95) at developmental levels different from where Sample E started (M = 3.68) and ended (M = 6.21).

3.3. Readiness

Given that the CSPCDR demonstrates acceptable reliability, content, and construct validity, results on the CSPCDR allow for an assessment of FL' readiness to address suicide stigma in FC. Table 3 presents the skills needed to address suicide stigma (Mason 2021) as well as the corresponding CSPCDR skills and post-training means on the CSPCDR to determine FL' readiness to address suicide stigma.

Table 3. FL' readiness to address suicide stigma.

Skill(s) Needed to Address Suicide Stigma (Mason 2021)	Corresponding CSPCDR Skill(s)	Sample 2 Post-Training Means on the CSPCDR Skill
Talk about suicide	Preaching/teaching to protect against suicide, Conducting memorial services or memorial ceremonies	Preaching/teaching to protect against suicide M = 3.22 (SD = 0.73) Conducting memorial services or memorial ceremonies M = 3.33 (SD = 0.69)
Address the skill deficits	Listening, Confidence, Safety planning, Referral	Listening M = 3.29 (SD = 0.76) Confidence M = 3.09 (SD = 0.78) Safety planning M = 2.99 (SD = 0.67) Referral M = 3.13 (SD = 0.51)
Practice vulnerability	Community building, Ministering to survivors	Community building M = 2.56 (SD = 1.01) Ministering to survivors M = 2.90 (SD = 0.76)
Address the theology of suicide; a focus on harm instead of purity violations	Theological reflection	Theological reflection M = 3.45 (SD = 0.74)
Appreciate that FC have a unique contribution; an artificial divide between mental health/suicide and faith; get leadership on board	Knowing your role	Knowing your role M = 3.44 (SD = 0.75)
Address cultural/systemic issues	Attitudes about suicide, Culture	Attitudes about suicide M = 3.28 (SD = 0.74) Culture M = 3.11 (SD = 0.77)
	Managing contagion and clusters, Self-care, Guilt	Managing contagion and clusters M = 3.21 (SD = 0.64) Self-care M = 3.35 (SD = 0.64) Guilt M = 3.17 (SD = 0.82)

4. Discussion

The CSPCDR seems to reliably capture FL' developmental level on 15 suicide prevention skills, suggesting that the CSPCDR measures developmental level in a stable manner,

consistent with Ross (2006), who has found that self-assessments are reliable. Results support the CSPCDR's construct validity, consistent with Cronbach and Meehl's (1955) testable hypotheses of change across occasions and groups. Regarding the CSPCDR's development using grounded theory, Jonsson and Svingby (2007) found that expert opinion is the "number one route to get empirical evidence [of construct] validity" of scoring rubrics (p. 136).

Given the complexities inherent in addressing suicide stigma in FC, it is important that FL develop a multiplicity of skills. Results suggest that FL may be ready to address suicide stigma in their FC in many areas. Sample 2 post-training means on the CSPCDR suggest three areas for improvement in FL' skills, which FL rated at the fundamental stage (a rating between 2.0 and 2.99), representing skills that FL use after the first encounters with suicidal people, but that do not work long-term (Mason et al. 2019). The three skills at the fundamental level are: Community building (M = 2.56, SD = 1.01), Ministering to survivors (M = 2.9, SD = 0.76), and Safety planning (M = 2.99, SD = 0.67). These results suggest that, on average, participants agreed with the statements "My faith community has some conversation about suicide but is unsure what to do,", "When a suicide death happens, I meet with friend(s) and family member(s)/the survivor(s) soon after the funeral but not long-term,", and "When a suicidal person talks to me, I am aware of some invitations to talk about suicidal thoughts.". In order to move to the practical level and to more effectively address suicide stigma in their FC, FL need more training on these three skills. Based on Mason (2021), these seem to be complex skills unique to suicide prevention in FC and seem to include the following aspects: community building includes helping congregants understand that no one "has it all together", a congregant is not "tainted" by the stigma of suicide, and congregants should receive the help they seek. Ministering to survivors includes helping congregants understand that suicide does not "taint" grieving congregants, who deserve the ministry of their FC. Safety planning includes addressing the stigma that keeps suicidal individuals from seeking help, but includes FC developing the skills to help suicidal congregants. Longer trainings seem to be associated with higher post-training self-ratings and could include these three skills.

5. Strengths, Limitations, and Future Studies

A homogeneous convenience sample as well as using several samples which allowed for testing hypotheses of change across occasions and groups were strengths of the study. It is important to note that the results are only applicable to the Protestant respondents in this study (Tsang et al. 2017). Different cohorts, such as other religious groups, should be investigated. Reliability and validity are not established by any single study, but by patterns of results across multiple studies (Messick 1975). Future research needs to take into account the fact that respondents begin and end training at different developmental levels. It may be that the goal of training is to increase self-ratings up to the practical level, level three, especially on the skills of community building, ministering to survivors, and safety planning, in order for FL to be able to address suicide stigma in FC.

6. Conclusions

The CSPCDR's psychometric properties allow for the ongoing evaluation of FL' readiness to address suicide stigma in FC. Given the high rate of suicide in the U.S. and the key role of FL in suicide prevention, it is vital that FL are trained for their role, especially in developing the skills for addressing suicide stigma in their FC.

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Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

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Appendix A

The Clergy Suicide Prevention Skills Developmental Rubric (CSPCDR). Circle the statement in each row that best describes you.

Skill	Beginning	Fundamental	Practical	Inspiring
Attitudes about suicide	I haven't thought much about my attitudes about suicide	I am beginning to reflect on my attitudes about suicide.	I am non-judgmental when a suicidal person talks to me, when a person who has attempted suicide talks to me, and when a survivor talks to me after his/her friend or family member's suicide death.	I help others reflect on their attitudes about suicide.
Culture	I haven't thought much about how culture might affect suicide.	I am beginning to see the importance of culture but I'm not sure how to take culture into account.	When a suicidal person talks to me, I take her/his culture into account. (For example, is the suicidal person experiencing discrimination?)	I invite individuals and family members to talk about their culture and how their culture affects their engagement with suicide.
Theological reflection	I haven't thought much about my theology of suicide.	My theology of suicide is pretty standard.	My theology of suicide addresses the full complexity of suicide prevention, intervention and postvention.	My theology of suicide is integrated with my theologies of life, death, suffering and community.
Community building	My faith community is silent about suicide.	My faith community has some conversation about suicide but is unsure what to do.	My faith community acknowledges suicide and faith community members watch over each other.	My faith community has open conversation about suicide, has authentic relationships with each other, and openly ministers to one another.
Preaching/teaching to protect against suicide	Preaching and teaching don't have anything to do with suicide prevention.	In my faith community, I have on occasion mentioned suicide.	I can preach or teach about suicide.	I preach or teach to promote life to suicidal listeners.

Skill	Beginning	Fundamental	Practical	Inspiring
Knowing your role	I believe that suicide is a spiritual problem.	I believe that suicide is both a spiritual and mental health condition.	When a suicidal person talks to me, I am clear about my role as a spiritual leader or mental health professional.	My role is to create a safe space where both the mental health and spiritual conditions can be discussed.
Listening	When a suicidal person talks to me, I am more aware of myself than of the person.	When a suicidal person talks to me, I listen and give advice.	When a suicidal person talks to me, I listen humbly without needing to know the answers.	When a suicidal person talks to me, I bring in a network of other listeners and mentor others in listening.
Confidence	When a suicidal person talks to me, I feel inadequate.	When a suicidal person talks to me, I have a few resources but I am not confident.	When a suicidal person talks to me, I'm confident about next steps.	When a suicidal person talks to me, I do all I can but I trust God as ultimately responsible.
Safety planning	When a suicidal person talks to me, I have no idea what to do.	When a suicidal person talks to me, I am aware of some invitations to talk about suicidal thoughts.	When a suicidal person talks to me, I know the right questions to ask.	I train others on what to do when a suicidal person talks to them.
Referral	When a suicidal person talks to me, I don't refer.	When a suicidal person talks to me, I am somewhat aware of my limitations of what I can do.	When a suicidal person talks to me, I know where to refer them for help.	I am part of a network or team of professionals who can help a suicidal person.
Postvention: ministering to survivors	When a suicide death happens, I do not meet with friend(s) and family member(s)/the survivor(s) once the funeral is done.	When a suicide death happens, I meet with friend(s) and family member(s)/the survivor(s) soon after the funeral but not long-term.	When a suicide death happens, I know how to care for the friend(s) and family member(s)/the survivor(s) long-term.	As I minister to friend(s) and family member(s)/the survivor(s), I actively confront the silence and shame following a suicide death.
Conducting memorial services or memorial ceremonies	During a suicide funeral or memorial service, I am thinking about myself and how I'm doing.	During a suicide funeral or memorial service, I am focused on myself and on the friend(s) and family member(s)/the survivor(s).	I know how to conduct a suicide funeral or memorial service that is helpful to survivor(s) and faith community member(s).	I conduct a suicide funeral or memorial service keeping in mind that the healing begins at the service but continues into the future and that the message can help change the conversation about suicide.

Skill	Beginning	Fundamental	Practical	Inspiring
Postvention: Managing contagion and clusters	I don't know what contagion and clusters are.	I know what contagion and clusters are but I don't know how to manage them.	During a suicide funeral or memorial service, I know how to strike a balance between talking about suicide without making it sound like a good solution to life's problems.	I manage contagion and clusters in the funeral or memorial service and beyond.
Self-care	I am unaware of my own needs.	I know I have needs but I feel guilty when I take care of myself.	When a suicidal person talks to me, I know how to reach out for support for myself if needed.	I advocate for self-care of others.
Guilt	I feel responsible and guilty after a suicide.	While I feel some guilt after a suicide, I realize that I don't have full responsibility.	When a suicide death happens, I do not take on guilt.	I help others process their guilt following a suicide death.

References

Borg, Walter R., and Meredith D. Gall. 1989. *Educational Research: An Introduction*, 5th ed. White Plains: Longman.

Borges, Christina, Karen J. Mathewson, and Louis A. Schmidt. 2018. Short-term test-retest reliability of Respiratory Sinus Arrhythmia (RSA) in young adults. *Journal of Psychophysiology* 32: 85–96. [CrossRef]

Creswell, John W. 2007. *Qualitative Inquiry and Research Design: Choosing among Five Approaches*. Thousand Oaks: Sage.

Cronbach, Lee J., and Paul E. Meehl. 1955. Construct validity in psychological tests. *Psychological Bulletin* 52: 281–302. [CrossRef] [PubMed]

Davis, James A., and Tom W. Smith. 1980. *The General Social Surveys, 1972–1980: Cumulative Codebook*. Chicago: NORC.

Domino, George, Daniel Moore, Laurie Westlake, and Linda Gibson. 1982. Attitudes toward suicide: A factor analytic approach. *Journal of Clinical Psychology* 38: 257–62. [CrossRef]

Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon & Schuster.

HHS. 2012. U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for SP. In *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. Washington, DC: HHS.

Jager, Justin, Diane L. Putnick, and Marc H. Bornstein. 2017. More than just convenient: The scientific merits of homogeneous convenience samples. *Monographs of the Society for Research in Child Development* 82: 13–30. [CrossRef] [PubMed]

Jonsson, Anders, and Gunilla Svingby. 2007. The use of scoring rubrics: Reliability, validity and educational consequences. *Educational Research Review* 2: 130–44. [CrossRef]

Marshall, Doreen S. 2005. Clergy Workgroup on Suicide Prevention and Aftercare. Retrieved from Suicide Prevention Resource Center Website. Available online: http://www.sprc.org/sites/sprc.org/files/library/faithbasedconf.pdf (accessed on 17 May 2021).

Mason, Karen. 2021. Suicide stigma in Christian faith communities: A qualitative study. *Religions* 12.

Mason, Karen, Monica Geist, and Mollie Clark. 2019. A developmental model of clergy engagement with suicide: A qualitative study. *OMEGA—Journal of Death and Dying* 79: 347–63. [CrossRef] [PubMed]

Mason, Karen, M. Geist, R. Kuo, D. Marshall, and J.D. Wines Jr. 2021. Clergy as suicide prevention gatekeepers. *Journal of Pastoral Care & Counseling* 75: 84–91.

Mason, Karen, Esther Kim, and W. Blake Martin. 2020. Clergy use of suicide prevention competencies. *OMEGA—Journal of Death and Dying* 8: 404–23. [CrossRef] [PubMed]

Mason, Karen, Pablo Polischuk, Raymond Pendleton, Elizabeth Bousa, Rebekah Good, and James D. Wines Jr. 2011. Clergy referral of suicidal individuals: A qualitative study. *Journal of Pastoral Care & Counseling* 65: 1–11.

Messick, Samuel. 1975. The standard problem: Meaning and values in measurement and evaluation. *American Psychologist* 30: 955–66. [CrossRef]

National Action Alliance for Suicide Prevention: Faith Communities Task Force. 2019. *Suicide Prevention Competencies for Faith Leaders: Supporting Life before, during, and after a Suicidal Crisis*. Washington, DC: Education Development Center.

Ross, John A. 2006. The reliability, validity, and utility of self-assessment. *Practical Assessment, Research and Evaluation* 11. [CrossRef]

Tsang, Siny, Colin F. Royse, and Abdullah Sulieman Terkawi. 2017. Guidelines for developing, translating, and validating a questionnaire in perioperative and pain medicine. *Saudi Journal of Anaesthesia* 11: S80–S89. [CrossRef] [PubMed]