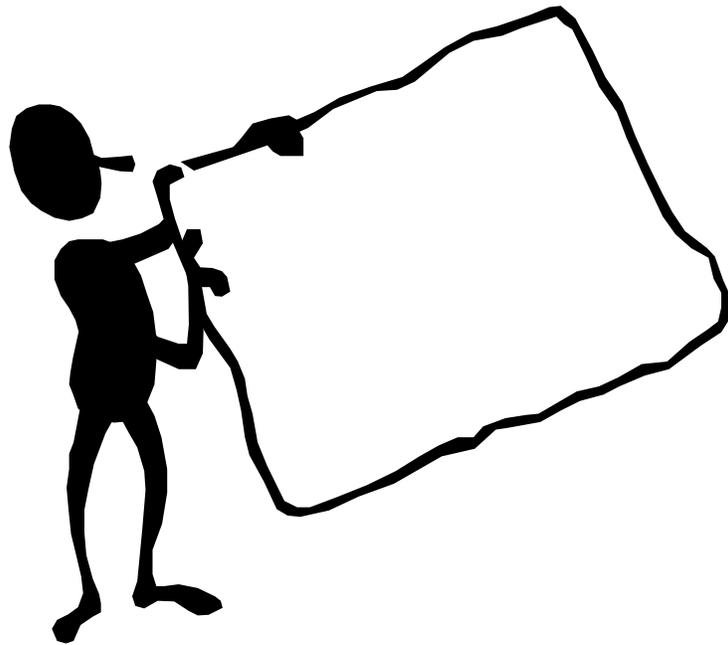


FIELD LEADERSHIP COUNCIL

2002 REPORT

**“WORKLOAD, DSS AND
ASSESSMENT COMMITTEE”**

Outcome Measures



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INTRODUCTION

In the last fifty years health care has seen its own renaissance in both technology and delivery of care. Many hospitals saw the delivery of pastoral care as a vital part of their mission. Over the years the emphasis hospitals put on pastoral care seems to have waned. Interest in outcomes has grown as a result of pressure to contain rapidly increasing cost and provide state of the art services that prove their effectiveness. This emphasis has led hospital administrators to look at every service that is provided. Pastoral care departments are no longer exempt from examination and find themselves competing alongside departments that present more persuasive arguments for funding.

Documenting outcomes is now a growing interest among pastoral care providers. The statement, "You can't measure the spirit," is now changing to "I don't know how to measure the spirit. Teach me how." This desire to engage process and move beyond traditional ideas has been a focal point of chaplain training.

When we look at the issue of outcome measures we must ask ourselves who might be interested in this information. The answer to this question could have significant impact on the type of outcome information we provide. Interested parties (stakeholders) include other pastoral care providers, the recipients of our services, managers who make decisions regarding allocation of resources, clinicians who provide other services to the patient, health care monitoring organizations, and researchers.

Outcome measures are divided into two classes. These two classes of outcome measures are called individual and normative outcomes.

Individual outcome assessments do not usually use instruments, which have standardized norms. Thus, they may not require specialized expertise to develop and interpret. Individual outcome reporting can be as easy to document as a customer satisfaction increase or reporting a patient's improvement in mood. The reporting of progress made on specific treatment goals contained in the treatment plan are individual outcome measures of which most chaplains are familiar. When a chaplain effectively documents a patient's improvement in intensity and frequency of anxiety about dying the chaplain has reported effectively an individual outcome of his/her intervention.

Normative outcome assessments tend to focus on the scientific method. This class of outcome measurement uses instruments that have been normed and shown to pass such tests as reliability and validity. A number of researchers have been vocal about the need for additional study using these normative approaches. Larry VandeCreek, Harold Koenig and others have made considerable progress in this area.

Those of us on the Field Leadership Committee 6 hope this information will stimulate greater interest in exploring this area. We also hope this work will increase expertise of VA chaplains in measuring and reporting the outcome of their work so that each stakeholder group will recognize the value of chaplain services.

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*The Discipline for Pastoral Care Giving:
Foundations for Outcome Oriented Chaplaincy*
(New York: The Haworth Pastoral Press, 2001)
Reviewed by Gary Rolph, M.C.S., B.C.C.

How do chaplains show measurable outcomes or “good results” when they visit? As health care has shifted from the expertise of the practitioner to the felt and implied needs of the patient (and often the felt and implied needs of the insurance company), patient care has become a tightly organized “commodity.” Chaplains no longer have a “right” to be present with patients. Not only must they compete with others to provide “spiritual care,” they must also show that their presence adds value.

Arthur M. Lucas, director of Spiritual Care Services, Barnes-Jewish Hospital (St. Louis, MO) developed and refined a model of spiritual care that he calls “The Discipline for Pastoral Care Giving.” The model is a template into which, after communication with the patient, the clinician enters the essence of the patient’s spirituality (Lucas calls this the patients “Needs, Hopes, and Resources”). The discovery of the patient’s spirituality allows the clinician to propose various “desired contributing outcomes” (Lucas says this is like asking ourselves, “What is our prayer for the patient?”). These outcomes are consolidated into a plan that identifies current issues and interventions to move towards those desired contributing outcomes. The interventions, as they are tried, are measured against the desired goals, and a determination is made to reassess and reflect on the further needs and outcomes (if any) of the patient.

Credit Arthur Lucas with developing and refining a strong methodology for patient-centered spiritual care. His chaplains, many of whom contribute chapters to the book, are enthusiastic supporters of a method that helps them see how important spiritual care is. One of his staff, Robert J. Rodrigues Yim, wrote: “I worked with the Discipline enough to find a

sufficient objectivity that ironically provided a distancing that actually allowed me to relax and afforded me to be closer and more available to patients in their narratives” (p. 74).

There is much that provokes good thought. I appreciated the way in which Rev. Lucas was able to re-orient his department from “what chaplains do” to “what patients need.” The Discipline, and Chaplain Lucas’ supervision, has allowed chaplains to branch off into areas outside that of “normal” hospital visitation. For instance, Chaplain Lawrence Olatunde has been working with local churches to re-integrate black “violent victims of violence” back into a faith community. Rev. Olatunde’s Chaplaincy practice extends beyond the Emergency Room, where he is assigned, to the patient throughout the continuum of care. He is looking at the whole human being, not just the body in the ED.

The book suffers in two ways. First, Rev. Lucas and his chaplains speak in theological terms. Although “discipline” is a perfectly good way to speak of methodology, the term is not widely used in health care. Using it tends to “distance” the provision of Chaplaincy care from the provision of spiritual care by nurses and medical practitioners.

Second, the book appears to plod along. The book is not an easy read. At times it reads like the transcript of a lecture or the notes from a workshop. The book either needs further editing or else a different way to introduce the model concept.

I would encourage all chaplains to read this book and think deeply about its implications for quality spiritual care. Chaplains do “have an active role in the healing process parallel with nursing and medicine” (Shostram, “An Adaptation of the Discipline,” p. 151). We need to show that chaplains are specialists in spiritual care, and that our work provides tangible outcomes (patient satisfaction, increased coping, stress reduction, shorter hospital stays). When we fail to

provide such measured indicators, the chaplain's role and function looks superfluous. We then become an expendable commodity.

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Gary,

A few quick responses.

1. Your review is quite fair.
2. You are by far not the first person to point out what a hard read it is, especially the first chapter which I wrote. I think I tried to accomplish too much inside one chapter/article. The plodding style does seem to work well with students, however. They seem to be able to think along, pick it up again later, etc.
3. I did not reorient the chaplaincy staff. I noticed a pattern in their best chaplaincy. I'll accept some credit for noticing, for capturing the model running through their best care. I reflected that back to them and away we went.
4. In the words we use here, the shift we have made is more from "what chaplains do" to "what difference do we make", "how is 'Mrs. Smith' better off because we were here than if we were not here". That forms the core of our accountability.
5. You have an interesting thought about using the word "discipline."

We have not found it distancing here in any person-to-person sense. Crystalizing our distinctness from spiritual care offered by others has been a byproduct. I think that is a good thing as opposed to the easy stance of spiritual care as something "anyone" can do. For instance we do make a distinction between a spiritual screening, which, given a set of questions, most anyone can do and spiritual assessment for which a chaplain is needed.

Then again we only very infrequently talk about the Discipline as such with nurses or doctors or professionals in other disciplines around here. Our thought is they don't really need to know (or usually want to know) our working infrastructure. Just like I don't need to know the working infrastructure of respiratory therapy. Others do seem to like the experience of working with us as we operate within the model. In instances when we have presented this to physicians, the usual response is a sense of kinship--having a clinical process they can recognize as such and appreciate from within their own medical perspective.

6. In identifying spiritual care specific desirable contributing outcomes be careful to speak from our unique perspective for a patient or patient population. Be assertive and be able to back it up. Allowing others to tell us what we must demonstrate gets things more

confused than I can handle.

7. Please do not settle into the idea that being able to point to contributing outcomes will make chaplaincy indispensable. Nothing will make us indispensable. Orienting to outcomes and what difference we make instead of what we intend to do will improve our care. That is the only thing we can insure (no pun intended). Even if/when we are clear and substantive in identifying the contributions we make to patients, to the team, to the mission of the hospital, decisions can still be made to do without those particular contributions, or that ("sadly") the hospital just can not afford what it takes to deliver those contributions. We continue to be well supported here and I try to stay realistic.

Hope this helps,
Art

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New England VA Health Care System West Haven CT VAMC

With the change(s) of Chief of Chaplains, the Extended Care unit (Rehab, Spinal Cord, Palliative, Respite) expressed a concern that their patients were not visited regularly. When I took over the leadership role for the Chaplains, I brought this to the attention of my peers. What we discovered is that while visits were being made, they were not always documented. I therefore suggested that weekly I would monitor the list of patients found on the unit Fridays, and do a full search of all of the notes written by the chaplains the seven days previous.

Currently we have three different notes:

- Pastoral Assessment
- Sacramental Ministry
- Chaplain's Note

While very labor intensive, from a low of 72.4% visitation rate, in spite of reduced staffing, in the past quarter we are documenting more visits, and the last 5 weeks, we have hit a pattern of 100% compliance.

Coming from a Nursing Home training where the adage was "If it's not written, it's not done," I placed a performance premium of documentation. Each month I collect the numbers of notes written by my staff - again the numbers speak for themselves. My numbers are out there with the rest of the staff's - I believe in servant leadership (I cannot ask of them what I do not of myself). I publish the results for internal consumption at our staff meetings. The results have been dramatic, this according to QM feedback.

Sergei Bouteneff
Chief, Chaplain Service

- ✓ The expectation is that each patient on the extended care unit receives no less than one pastoral/chaplain visit a week, every week, during their stay, more as requested/indicated by condition.
- ✓ The expectation is that each palliative care patient receive no less than two visits a week (etc.)
- ✓ Our chaplain service is STILL missing proper coverage as a result of unrecruited/unfilled FTEE positions.
- ✓ The data is as follows:

Mar.	29/02	%	0	1	2	3	4	5+	Total #
1-3 Q. G. T.	722/808	89.35	550	219	190	178	128	112	2211

Date	Visited/Tot. Pop.	%	Numbers of visits/encounters						
			0	1	2	3	4	5+	Total #
Apr. 05	31/31	100	0	07	07	02	08	07	94

3Q. Totals

Date	Visited/Tot. Pop.	%	Numbers of visits/encounters						
			0	1	2	3	4	5+	Total #
Mar. 29	30/30	100	00	10	03	04	08	04	72
Mar. 22	32/32	100	00	09	02	11	05	01	71
Mar. 15	31/31	100	00	05	05	02	01	17	107
Mar. 08	30/30	100	00	08	05	03	08	08	93
Mar. 01	24/29	85.75	05	05	03	00	04	12	87
Feb. 22	26/27	96.30	01	05	03	02	05	10	88
Feb. 15	29/32	90.62	03	09	01	01	04	15	110
Feb. 08	31/31	100	00	05	06	11	05	04	90
Feb. 01	29/29	100	00	06	11	05	04	03	74
Jan. 25	30/30	100	00	08	05	03	06	08	91
Jan. 18	26/29	89.65	03	05	06	10	05	00	76
Jan. 11	26/29	89.65	03	09	03	08	05	01	64
Jan. 04	30/31	96.77	01	06	15	05	03	01	68
2Q. Totals	325/363	89.53	16	90	68	65	63	84	1091

Date	Visited/Tot. Pop.	%	Numbers of visits/encounters						
			0	1	2	3	4	5+	Total
Dec 28	25/29	86.2	05	08	06	09	01	00	51
Dec 21	29/31	93.5	02	11	11	07	00	00	54
Dec. 14	31/31	100	00	14	03	06	05	02	6856
Dec. 07	31/32	96.88	01	13	05	06	03	01	58
Nov. 30	22/24	91.66	02	13	10	09	04	00	36
Nov. 24	25/26	96.61	01	09	10	21	12	05	57
Nov. 16	23/31	74.19	08	10	09	04	00	00	40
Nov. 09	31/31	100	00	09	10	03	05	04	78
Nov. 02	25/32	78.1	07	04	16	27	12	05	49

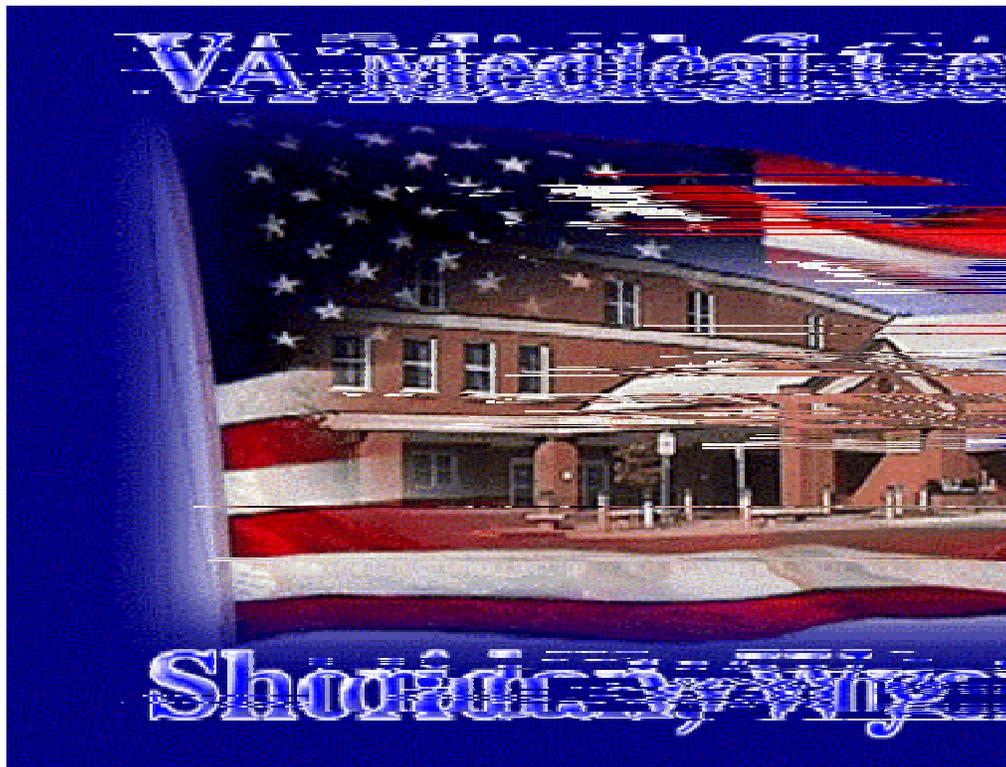
Oct.	26	29/31	93.5	02	08	07	05	07	02	75
Oct.	19	21/29	72.4	08	10	08	02	01	00	36
Oct.	12	29/29	100	00	00	10	07	09	02	53
Oct.	05	29/31	93.5	03	13	10	05	00	00	48
<i>1Q. Totals</i>		<i>341/387</i>	<i>88.11%</i>	<i>40</i>	<i>122</i>	<i>115</i>	<i>111</i>	<i>57</i>	<i>21</i>	<i>1026</i>

1. The measurement is taken from Saturday to Friday (2PM) every week.
2. Some patients may be admitted and discharged within that time period, they do not enter the survey parameters (ex. Spinal cord, weekend respite, etc.)
3. Some patients may be admitted/transferred back from the Medical wing on Friday.

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SPIRITUAL RECOVERY SUPPORT GROUP



Point of Contact: Chaplain Everett L. Wright
Phone: (307) 672-1633

The purpose of the Spiritual Recovery Support Group (SRSB) is to provide intervention and support to those Veterans suffering from low self-esteem because of significant spiritual injuries as listed in the Multilevel Spiritual Assessment (MLSA). It is an attempt to bring the spiritual components of faith and God's grace to bear on treatment and enhance the health care recovery of Veterans. The SRSB is not only a quest to find and/or renew one's spiritual vitality, it becomes a vehicle for change and growth. When God's gift of spiritual faith and grace is applied, it is good medicine.

One of the many facets of God's grace is the acknowledgement of "God's Ability" working in us, empowering us to make changes in our lives that we cannot do in our own ability. It is this change agent of grace that helps us to alter our histories, experience forgiveness, redemption, and

renewal of trust and hope, in the midst of tragedies and loss. Grace becomes the power that transforms us away from the negatives to the positives of life and builds self-esteem.

When new members enter the SRSG, they are assessed for significant spiritual injuries (MLSA) and how they feel about themselves in terms of self-esteem. Both of these assessments are documented; when Veterans exit the group, they are re-assessed. Each of these scores is compared for improved outcomes.

Section 1: DESCRIPTION OF THE METHOD, PRACTICE, PROCESS OR TECHNIQUES

When a Veteran is given a Multilevel Spiritual Assessment Test (MLSA), the results of this test are put into the MLSA computerized software program and are scored automatically. A summary of this information is then transferred to an MLSA template and sent to the treatment team, and becomes part of the Veteran's records. The summary highlights the test results, and the significant spiritual injuries listed by the Veteran.

A significant spiritual injury is defined as answering any of the following eight MLSA spiritual injury questions with an "often" or "very often" answer. Not that the answers "sometime" and "seldom" are not injuries of importance, but in terms of frequency and how often they are felt, they are not as significant as feeling the emotions "often" or "very often."

- Guilt over past behaviors
- Grief, bereavement
- Life lost its meaning or purpose
- Despair and hopelessness
- Anger and resentment blocking peace of mind.
- Doubts or disbelief in God
- Fear or worry about death
- That life or God has treated you unfairly

There are five possible answers to these eight spiritual injury questions:

- Very often
- Often
- Sometimes
- Seldom
- Never

When a Veteran scores a significant spiritual injury, it is recorded in the summary of the MLSA template sent to the treatment team, and a recommended intervention is made that the Veteran attend the SRSG. Attendance at the SRSG is voluntary.

At the beginning of each SRSG session members sign a specially designed attendance sheet (see SRSG Attendance Sheet). The group opens with introducing themselves. New members are given informational handouts on the history, purpose, goal, and ground rules of the SRSG emphasizing spiritual recovery and support. Those who haven't taken the MLSA are scheduled to do so. A Personal Worth Appraisal form is given to all new group members to complete and return to the Chaplain.

Presently the SRSG is meeting twice a week. Mondays are open days when any group member can bring up any problem, issues or comments they would like to discuss. On Tuesday, there is a 15 minute educational lecture given on a topic or subject (see

lecture topics). The remainder of the time is discussion on the lecture subject. Some of the techniques used in the group are: interpretation, confrontation, self-disclosure, active listening, linking, role playing, reframing, group discussion, sharing of personal story and experiences, and one-on-one. Progress notes document all sessions and each Veteran's participation.

LECTURE TOPICS

Guilt	Finding Peace When You're Burdened With Guilt ⁴⁰ Overcoming Guilt with Faith and Love ³² From The Alienation of Guilt to the Reconciliation of Forgiveness ² Guilt ³
Forgiveness	Finding a Way to Forgive ²⁵ Learning How to Forgive Yourself ³³
Grief	Walking With God Through Grief and Loss ²⁹ Grief and Loss ³ Taking the Time You Need to Grieve Your Loss ³⁰ Good Grief ¹⁰
Anger	Dealing with Anger ²⁷ Skills for Dealing With Anger (Ev Wright) Nurturing Your Self with Self-esteem ²⁶
Anxiety	Coping With Panic & Anxiety Disorders ³⁵
Depression	Climbing Up from Depression ³⁶
Suicidal	Dealing With Suicidal Feelings ³⁷
Addiction	13 Steps To A More Positive You ³⁹
Assertiveness	Assertiveness (Ev Wright)
Change	Seven Steps to Freedom In Christ ¹ Nine Basic Needs to Growth ² Prescription For Change (Ev Wright) Change and Growth (Ev Wright) The Blockage of Change (Ev Wright) Father Martin's 6 Words for Change ²⁴
Spirituality	Spirituality: The Heart of Recovery (Ev Wright) Recovery Process II (Ev Wright)
Grace	What is Grace ⁶ What Ever Happened to Sin? (Ev Wright)
Faith	Faith (Ev Wright) Wholeness (Ev Wright)
Holy Spirit	Holy Spirit (Ev Wright)
Prayer	Prayer (Ev Wright)
Worship	The Benefits of Attending Worship ⁴ The Faith Factors ⁴

BIBLE STUDY

For those SRSG members who want to know more about God's grace and how it works, a weekly Bible Study is offered.

We use two books in our Bible Study at separate times.

Grace the Power to Change by James Richards
(see recommended resources)

Victory Over the Darkness by Neil Anderson
(see recommended resources)

In the book, Grace the Power to Change⁶, Richards defines God's grace as God's ability working in man making him able to do what he cannot do in his own ability. Richards talks about grace in the heart, about the doorway of the heart, and God's ability that works from our heart. He says there's a place of rest where we cease from our labors, and yet, we still enter into the Promised Land. This rest is the place of grace.

Neil Anderson's book, Victory Over the Darkness¹ and his second book, sequel to his first book, Bondage Breaker¹, deals with identity, maturity, and spiritual growth. He looks at personal and spiritual conflicts, and lays out a plan for spiritual growth and Christian discipleship. Mr. Anderson was a professor of Practical Theology at Talbot Seminary. His book, Victory Over the Darkness¹, has many graphic illustrations that help one to understand spiritual struggles and growth.

Copies of these books are in the hospital library for Veterans to check out.

Normally it takes five to six months to work through one of these Bible study books. Since February of 2000 to June 2001, we have completed three full cycles.

Section 2: HOW SRSG WAS INVENTED/DISCOVERED

HISTORY OF DEVELOPMENT

While attending one of this Medical Center's weekly Alcohol and Drug After-Care meetings in February 2000, Chaplain Ev Wright mentioned the eight spiritual injuries listed in the Multilevel Spiritual Assessment Test (MLSA) given to all Veterans who enter the alcohol and drug program.

Chaplain Wright talked about the need to address the significant injuries listed in the MLSA by applying God's grace as a way to bring about inner healing of these emotions thereby enhancing the health care recovery of Veterans.

After the meeting a couple of Veterans asked Chaplain Wright if he would be willing to meet with them and talk more about these issues. This was the beginning of the Spiritual Recovery Support Group (SRSG).

The group began meeting once a week for 45 minutes. Currently, depending on the need of the group, it meets either once or twice a week (Mon - Tues at 10 am). Additionally, for those group members who want to learn more about God's grace and deepen their understanding of how to apply it, a weekly Bible Study meets on Wednesday for 45 minutes at 10 am

Veterans with psychiatric, stress, or addiction disorders are at high spiritual risk. They suffer from low self-esteem/self-worth because of feelings of failure to effectively deal with their mental disorders, stress disorders, or addictions. These Veterans judge themselves harshly and beat up on their own self-esteem. They start sliding down the slippery slope of negative self talk from feeling not OK about themselves, thinking they don't deserve to be forgiven by God for their relapses, mistakes and failures, and believing that God could never forgive them because they can't forgive themselves. These Veterans feel they are not worthy of God's mercy and grace and hit bottom not allowing themselves to be rescued. Any movement for them is an upward change; they can't go any lower than they already are.

Process - Change and Growth

Bringing in the idea that God sees them of infinite worth and value, and that God wants them to treat themselves with His grace and mercy as His precious child, can be an important concept that can help them to recover and move out of the pit toward healing, growth, change, and a more positive self-esteem and self-worth.

As they begin to bring God into the picture and start seeing themselves and treating themselves as a precious child of God with His grace, receiving forgiveness and forgiving themselves and treating themselves more kindly, change begins and they are empowered. As they continue to apply God's grace to their lives, they become more aware and accepting of God's grace working in them to help them do the things they could not do by themselves. There are some things we are powerless to overcome in our own strength, but God specializes in doing the impossible.

St. Augustine once said that God has so many good gifts to give us, but our hands are so full of other things that we can not receive them. SRSG is about looking at the things keeping us from receiving these gifts, and letting go of them in order to receive the great gifts He has for us.

Grace - God's Ability Working In Us

The concept of God's grace, defined as God's ability working in man, making him able to do what he cannot do in his own ability, is a liberating and powerful concept. God's grace becomes the power to help us change and alter our history, our thinking, feeling, and behavior.

Using this concept of God's grace, the SRSG becomes not only a quest to find our spiritual vitality, but it becomes a journey of change and growth.

Grace becomes the vehicle (the power) that moves us from darkness to the light, from the negatives to the positives. It improves our self-esteem. The process of grace moves us from the alienation of guilt to the reconciliation of forgiveness. God's grace is His ability working in us, to help us change and grow!

<i>Change: Negative to Positive</i>			
<u>Spiritual Injury</u>	<u>Spiritual Health</u>	<u>Spiritual Injury</u>	<u>Spiritual Health</u>
Meaninglessness	Fullness of life	Miser	Joy
Chaos	Creativity	Curse	Blessing
Brokenness	Wholeness	Foolishness	Wisdom
Bondage	Freedom	War	Peace
Dread	Courage	Ingratitude	Gratitude
Helplessness	Power	Revenge	Mercy
Arrogance (Pride)	Humility	Faithlessness	Faithfulness
Greed	Charity	Denial	Awareness
Injustice	Justice	Aloneness	Intimacy
Indolence	Discipline	Isolation	Community
Hate	Love	Self-Hatred	Self-Acceptance
Control	Surrender	Death	Life
Alienation	Reconciliation	Grief	Peace-Acceptance
Fear	Faith	Anger	Anger-Management
Anxiety	Control of Anxiety	Disbelief in God	Belief in God
Harsh Self-judgments	Positive Self-Esteem	Inner Turmoil	Inner Peace
Counterfeit	Real	Deception	Truth
Bitterness	Forgiveness	Rebellion	Submission
Pride	Humility	Bondage	Freedom

Section 3: OUTCOMES MEASURED

The answers to the eight spiritual injury questions that each group member gives are annotated on an Improved Outcome Form. When the group member is about to graduate or leave the SRSG, he/she retakes the eight spiritual injury assessment. Both

10. Westberg Good Grief (Minneapolis: Fortress Press, 1997)

ADDITIONAL RESOURCES:

11. Bowman,
George W. III Dying, Grieving, Faith, and Family
(New York: Haworth Press Inc. 1998)
12. Capps, Donald Reframing - A New Method In Pastoral Care
(Minneapolis: Fortner Press 1990)
13. Chaplin, Marie
et. al Telling Yourself The Truth
(Minneapolis, MN: Bethany House Publishers 1980)
14. Ciarrocchi, Joseph W. A Minister's Handbook of Mental Disorders
(Mahwah, NJ: Paulist Press 1993)
15. Corey, Schneider,
and Corey Groups Process and Practice, third edition
(Pacific Grove: CA 1987)
16. Drilling, Eileen Anxiety & Worry
(Center City, MN: Hazelden Educational Materials 1992)
17. May, Geraldg Addiction & Grace (New York: Harper Collins 1988)
18. Gilbert, John P.
et.al. Spiritual Life (Nashville: Graded Press 1986)
19. Lester, Andrew D., Hope in Pastoral Care and Counseling
(Louisville: KY Westminster John Knox Press 1995)
20. Longaker,
Christine Facing Death and Finding Hope (New York: Doubleday
1997)
21. Tobin, Daniel R. Peaceful Dying
(Reading: MA Perseus Books 1992)
22. Rosellini &
Worden Of Course You're Anxious (Hazelden Foundation 1990)
23. Wright, Norman H. Winning Over Your Emotions
(Eugene: OR Harvest House Publication 1998)
24. Father Martin 6 words for Change (video)

CARE NOTES:

25. Finding A Way to Forgive Carol Luebering

26. Nurturing your Self with Self-Esteem**Louisa Rogers**

- | | |
|--|----------------------|
| 27. Dealing With Anger | Louisa Rogers |
| 28. Drawing on Faith to Fight an Addiction | Chris A. |
| 29. Walking With God Through Grief and Loss | Joyce Rupp |
| 30. Taking the Time You Need to Grieve Your Loss | Kathlyn S. Baldwin |
| 31. Dealing With Anger That Comes With Grief | Les Parrott |
| 32. Overcoming Guilt With Faith and Love | Christine A. Adams |
| 33. Learning How to Forgive Yourself | Matthias Neuman |
| 34. Losing Someone Close | Robert D. Giulio |
| 35. Coping with Panic and Anxiety Disorders | Louise Sommer |
| 36. Climbing Up From Depression | Bradshaw & Weber |
| 37. Dealing With Suicidal Feelings | Joan Wester Anderson |
| 38. Overcoming Everyday Anxiety | Anderson & Wheeler |
| 39. 13 Steps to a More Positive You | Eileen Flynn |

HOPE NOTES:

40. Finding Peace When You're Burdened With Guilt Karen Katafiasz

GROUND RULES/EXPECTATIONS - SRSG

1. The Spiritual Recovery Support Group (SRSG) is a journey or quest to find one's spiritual vitality and connection and apply it to enhance one's health care recovery. This group creates an atmosphere of acceptance and support, so the Veterans can talk about significant spiritual injuries and where they are in their spiritual journey.
2. It is not a place to argue religion or to impose one's religion or spiritual beliefs on another.
3. All Faiths are equal here. There are many paths to God. There is strength in our differences. It is expected that every group member will respect each other's religious/spiritual beliefs.
4. However, it is a place where each group member is encouraged to talk about their Holy Ground, how they came into their spirituality, their beliefs, and perhaps religious connection.
5. Group members are expected to:

Attend (SRSG) meetings regularly and on time.

Talk about their spiritual injuries.

Be open and honest in their self-disclosures.

Complete assignments (reading and written).

Participate in group discussions, be courteous and respectful.

Evaluate their progress/roadblocks toward recovering from their spiritual injuries.

Be willing to grow and make changes in their lives.

Respect, value, and support one another.

Work at breaking down the walls of alienation between themselves, others, and God.

Maintain confidentiality.

**Eight Spiritual Injuries MLSA
For Improved Outcome**

Date:

X = First MLSA done

O = Second MLSA done

Name _____ SSN _____

Program _____ In or Out Veteran _____

Religious Preference _____ Relationship with God _____

1. How often do you feel guilty over past behaviors?
 - (5) Very often
 - (4) Often
 - (3) Sometimes
 - (2) Seldom
 - (1) Never

2. How often do you feel sad or experience grief?
 - (5) Very often
 - (4) Often
 - (3) Sometimes
 - (2) Seldom
 - (1) Never

3. How often does anger or resentment block your peace of mind?
 - (5) Very often
 - (4) Often
 - (3) Sometimes
 - (2) Seldom
 - (1) Never

4. How often do you feel despair or hopelessness?
 - (5) Very often
 - (4) Often
 - (3) Sometimes
 - (2) Seldom
 - (1) Never

5. How often do you feel that life has no meaning or purpose?
 - (5) Very often
 - (4) Often
 - (3) Sometimes
 - (2) Seldom
 - (1) Never

6. How often do you have doubts or disbelief in God?

- (5) Very often
- (4) Often
- (3) Sometimes
- (2) Seldom
- (1) Never

7. How often do you worry about or fear death?

- (5) Very often
- (4) Often
- (3) Sometimes
- (2) Seldom
- (1) Never

8. How often do you feel that God or life has treated you unfairly?

- (5) Very often
- (4) Often
- (3) Sometimes
- (2) Seldom
- (1) Never

Personal Worth Appraisal Improved Outcomes¹

Name: _____
 SSN: (last four) _____
 Program: _____
 Out or In Veteran _____
 Religious Preference: _____
 Relationship with God: _____

Outcomes
 X = Entry
 O = Exit

	<u>Low</u>				<u>High</u>
1. How successful am I?	1	2	3	4	5
2. How significant am I?	1	2	3	4	5
3. How fulfilled am I?	1	2	3	4	5
4. How satisfied am I?	1	2	3	4	5
5. How happy am I?	1	2	3	4	5
6. How much fun am I having?	1	2	3	4	5
7. How secure am I?	1	2	3	4	5
8. How peaceful am I?	1	2	3	4	5

¹Victory Over the Darkness by Neil T. Anderson
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NAME _____

Mental Health Rehab Program

WEEK OF _____

Weekly Class Schedule

Sheridan VA Medical Center

Monday	Tuesday	Wednesday	Thursday	Friday	Sunday
8:00 a.m. Substance Education Auditorium Use	8:00 a.m. Substance Education Auditorium Use	Protestant Services begin at 9:00 a.m., Catholic Services at 11:00 a.m.			
9:00 a.m. Group Therapy Specialty Track (SA, PTSD, SMI) MHR Clients Only	9:00 a.m. Group Therapy Specialty Track (SA, PTSD, SMI) MHR Clients Only	9:00 a.m. Group Therapy Specialty Track (SA, PTSD, SMI) MHR Clients Only	9:00 a.m. Group Therapy Specialty Track (SA, PTSD, SMI) MHR Clients Only	9:00 a.m. Veteran Gov. Mtg Auditorium Rec Planning Group.	
10:00 a.m. Spirit Recovery Chaplain Wright Bldg 5 South	10:00 a.m. Spiritual Support Group. Chaplain Wright Bldg 5 South	10:00 a.m. Bible Study Chaplain Wright Bldg 5 South	10:00 a.m. Pat Estes & Dan Paustine Job Service-PTSD Group Rm 205	10:00 a.m. Community Re-entry Field lab	
11:00 a.m. Recreation for Leisure Bldg 5N	11:00 a.m. - Noon. Woman's Trauma Recovery Group Bldg 5 S	11:00 a.m. Recreation for Leisure Bldg 5N 11:30 CULINARY BLDG 86			
1:00 p.m. Specialty Track (SA, PTSD, SMI) MHR Clients Only	Challenge Clinic or community re-entry or field trips or activities 1-4 p.m.				

2:00pm Conversation 5 N	2:00pm Assertiveness/Anger Bldg 5N Hydro Relaxation BLDG 86	2:00pm Conversation 5N	2:00pm Assertiveness/Anger 5 N Hydro Relaxation BLDG 86		
3:00pm Relaxation Bldg 5 RM 209 Fitness Bldg 6	3:00pm Fitness Bldg 6	3:00pm Relaxation Bldg 5 RM 209. Fitness Bldg 6	3:00pm Fitness Bldg 6 Dual Diagnosis Bldg 5 RM 219		

AA MEETING WEDNESDAY AT 7:00 P.M.

5 S = PTSD Group Room, Building 5 RM 219-----5 N = SMI Group Room Building 5 RM 209

Date:

Day:

BIBLE STUDY

Attendance Sheet

Name	Last 4 SSN	Religious Pref	Program	Diagnosis	Relationship with God/Higher Power
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10					
11					
12					
13					

14					
----	--	--	--	--	--

SHERIDAN VAMC

Sheridan VAMC is located at the foot of the eastern slope of the Big Horn mountains in Northern Wyoming. It is a 146 bed medical center and contains 76 well maintained buildings on a 296-acre campus.

Our primary catchment area extends to Veterans from Wyoming, Montana, Colorado, Utah and Idaho. It is the only psychiatric hospital in VISN 19.

The bed compliment includes 46 psychiatric, 23 medical, a 50 bed Nursing Home Care Unit, and 27 Mental Health Rehabilitation residential beds.

There are approximately 60,000 annual outpatient visits in our comprehensive ambulatory care department. Within the last three years this medical center has activated four Community Based Outpatient Clinics (CBOC's) in Casper, Riverton, Gillette, and Powell, Wyoming.

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ACKNOWLEDGEMENTS

I would like to thank the following people who have unselfishly shared their ideas and encouragement to assist in developing this Best Practice.

Chaplain Ron Shell – Cheyenne, WY

Chaplain Melba Banks – Asheville, NC

Chaplain Charles Vance – Asheville, NC

Chaplain Jack Klugh – Fargo, ND

Chaplain Ted Bleck – Canandaigua, NY

Chaplain William Kinnaird – National Chaplain Center, Hampton, VA

4/16/01
Date 5/28/01

Eight Spiritual Injuries MLSA For Improved Outcome

X = First MLSA done
O = Second MLSA done

Name _____ SSN _____
Program O.S.A.T.S. In or Out patient OUT
Religious Preference UNKNOWN/NO PR. Relationship with God _____

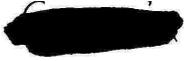
1. How often do you feel guilty over past behaviors?
 (5) Very often
 (4) Often
 (3) Sometimes 40 ↓
 (2) Seldom
 (1) Never

2. How often do you feel sad or experience grief?
 (5) Very often
 (4) Often
 (3) Sometimes 40 ↓
 (2) Seldom
 (1) Never

3. How often does anger or resentment block your peace of mind?
 (5) Very often
 (4) Often
 (3) Sometimes
 (2) Seldom
 (1) Never

4. How often do you feel despair or hopelessness?
 (5) Very often
 (4) Often
 (3) Sometimes 40 ↓
 (2) Seldom
 (1) Never

5. How often do you feel that life has no meaning or purpose?
 (5) Very often
 (4) Often
 (3) Sometimes
 (2) Seldom
 (1) Never



6. How often do you have doubts or disbelief in God?

- (5) Very often
- (4) Often
- (3) Sometimes
- (2) Seldom
- (1) Never

7. How often do you worry about or fear death?

- (5) Very often
- (4) Often
- (3) Sometimes
- (2) Seldom
- (1) Never

8. How often do you feel that God or life has treated you unfairly?

- (5) Very often
- (4) Often
- (3) Sometimes
- (2) Seldom
- (1) Never

3707

Date: VPB/01
5/24/01

**Personal Worth Appraisal
 Improved Outcomes**

Name: [REDACTED]
 SSN: (last four)
 Program: Sub Abuse
 Out or In Patient in
 Religious Preference: Prot
 Relationship with God: improving

Outcomes
 X = Entry .40
 O = Exit .65

 2550 U
 1
 0
 1

- | | <u>Low</u> | | | | <u>High</u> |
|------------------------------|------------|-----|-----|-----|-------------|
| 1. How successful am I? | 1 | 2 | 3 | (X) | 5 |
| 2. How significant am I? | 1 | 2 | 3 | (X) | 5 |
| 3. How fulfilled am I? | 1 | (X) | 3 | (4) | 5 |
| 4. How satisfied am I? | 1 | (X) | (3) | 4 | 5 |
| 5. How happy am I? | (X) | 2 | (3) | 4 | 5 |
| 6. How much fun am I having? | (X) | (2) | 3 | 4 | 5 |
| 7. How secure am I? | (X) | 2 | (3) | 4 | 5 |
| 8. How peaceful am I? | (X) | 2 | (3) | 4 | 5 |

$$\begin{array}{r} 40 \overline{) 16} \quad .40 \\ \underline{40} \\ 0 \end{array}$$

$$\begin{array}{r} 40 \overline{) 25} \quad .65 \\ \underline{40} \\ 0 \end{array}$$

**Acknowledgment to:
 Neil Anderson's book, Victory Over The Darkness,
 Chap. Seven. "You Must Be Real In Order To Be Right"**

MEDICAL RECORD

Progress Notes

NOTE DATED: 06/13/2001 08:44 PASTORAL CARE NOTE
VISIT: 06/13/2001 08:44 CHAPLAIN

SPIRITUAL RECOVERY SUPPORT GROUP (SRSG) - EXIT (4/24/01)
FOR IMPROVED OUTCOMES

WHEN J ENTERED THE SPIRITUAL RECOVERY SUPPORT GROUP, HE STATED THAT HE WAS AT GROUND ZERO AND KNEW NOTHING ABOUT SPIRITUALITY, HOW IT WORKED, HOW TO ACCESS IT.

WHEN HE WAS ABOUT TO LEAVE HOME AND ENROLL IN THE ALCOHOL RECOVERY PROGRAM AT OUR HOSPITAL, HIS NINE YEAR OLD SON SAID MAYBE GOD COULD HELP HIM. THIS GOT J TO THINKING. HE HAD ALWAYS BEEN A VERY CONFIDENT PERSON AND HAD RETIRED FROM THE AIR FORCE WITH A DISTINGUISHED MILITARY CAREER, BUT HE HAD BECOME AN ALCOHOLIC.

AT HIS GRADUATION CEREMONY, J SAID THAT THE ONE OF TWO THINGS HE WAS TAKING WITH HIM FROM THE PROGRAM THAT HE DIDN'T HAVE BEFORE, WAS HIS SPIRITUALITY, THANKS TO THE SPIRITUAL RECOVERY SUPPORT GROUP EXPERIENCE.

IN COMPARING J'S SIGNIFICANT SPIRITUAL INJURY SCORE WHEN HE FIRST CAME INTO THE SRSG TO HIS EXIT SCORE ON LEAVING THE GROUP, THERE WAS MUCH IMPROVEMENT. HE SHOWED A 40% DECREASE IN HIS FEELINGS OF GUILT, GRIEF, DESPAIR, AND HOPELESSNESS.

J'S SELF-ESTEEM SCORE HAD IMPROVED BY 25%.

J EXPRESSED HIS APPRECIATION TO STAFF FOR HIS SPIRITUAL BREAKTHROUGH.

DRAFT COPY - DRAFT COPY -- ABOVE NOTE IS UNSIGNED-- DRAFT COPY - DRAFT COPY
Author: WRIGHT, EVERETT L

SHERIDAN, WY Printed: 06/13/2001 15:30
Pt Loc: OUTPATIENT Vice SF 509



✓

2707



7/19/01 }
9/28/01 }
Date:

Eight Spiritual Injuries MLSA For Improved Outcome

X = First MLSA done
O = Second MLSA done

Name [redacted] SSN _____
Program SMJ In or Out patient elm
Religious Preference LDS Relationship with God _____

1. How often do you feel guilty over past behaviors?

- (4)
- (5) Very often
- (4) Often
- (3) Sometimes
- (2) Seldom
- (1) Never

4070

2. How often do you feel sad or experience grief?

- (5) Very often
- (4) Often
- (3) Sometimes
- (2) Seldom
- (1) Never

~~2090~~

3. How often does anger or resentment block your peace of mind?

- (4)
- (5) Very often
- (4) Often
- (3) Sometimes
- (2) Seldom
- (1) Never

2090

4. How often do you feel despair or hopelessness?

- (4)
- (5) Very often
- (4) Often
- (3) Sometimes
- (2) Seldom
- (1) Never

6090

5. How often do you feel that life has no meaning or purpose?

- (5) Very often
- (4) Often
- (3) Sometimes
- (2) Seldom
- (1) Never

~~2090~~



6. How often do you have doubts or disbelief in God?

- (5) Very often
 - (4) ~~Often~~
 - (3) Sometimes
 - (2) Seldom
 - (1) Never
- 60%0

7. How often do you worry about or fear death?

- (5) Very often
 - (4) ~~Often~~
 - (3) Sometimes
 - (2) Seldom
 - (1) Never
- 60%0

1346

8. How often do you feel that God or life has treated you unfairly?

- (5) Very often
 - (4) ~~Often~~
 - (3) Sometimes
 - (2) Seldom
 - (1) Never
- 40%0

Date: 7/19/1000/01
9/28/01

**Personal Worth Appraisal
 Improved Outcomes**

O = .875
 X = .425
 .450
 (45%)

Name: _____
 SSN: (last four) _____
 Program: SMT
 Out or In Patient In
 Religious Preference: LDS
 Relationship with God: _____

Outcomes
 X = Entry
 O = Exit

	<u>Low</u>				<u>High</u>
1. How successful am I?	1	X	3	(4)	5
2. How significant am I?	1	2	X	4	(5)
3. How fulfilled am I?	1	X	3	(4)	5
4. How satisfied am I?	1	X	3	(4)	5
5. How happy am I?	1	X	3	4	(5)
6. How much fun am I having?	1	X	3	4	(5)
7. How secure am I?	1	X	3	(4)	5
8. How peaceful am I?	1	X	3	(4)	5

$$\begin{array}{r} 40 \overline{) 17} \\ \underline{17} \\ 0 \end{array}$$

$$\begin{array}{r} 40 \overline{) 35} \\ \underline{35} \\ 0 \end{array}$$

**Acknowledgment to:
 Neil Anderson's book, Victory Over The Darkness,
 Chap. Seven. "You Must Be Real In Order To Be Right"**

MEDICAL RECORD

Progress notes

NOTE DATED: 09/10/2001 12:59 PASTORAL CARE NOTE
ADMITTED: 07/16/2001 10:18 RESIDENTIAL-SMI

SPIRITUAL RECOVERY SUPPORT GROUP (SRS) - EXIT
FOR IMPROVED OUTCOMES

WHEN J [REDACTED] ENTERED THE SRS, HE WAS SUFFERING FROM A LOW SELF-ESTEEM
BECAUSE OF SIX SIGNIFICANT SPIRITUAL INJURIES IN THE AREAS OF:

- GUILT
- ANGER AND RESENTMENT
- DESPAIR AND HOPELESSNESS
- DOUBTS OR DIBELIEF IN GOD
- WORRY OR FEAR OF DEATH
- FEELINGS THAT GOD OR LIFE HAD TREATED HIM UNFAIRLY.

J [REDACTED] ATTENDED ALL SRS MEETINGS & BIBLE STUDY MEETINGS. HE WORKED HARD AT
APPLYING GOD'S GRACE TO HIS LIFE AND IN MAKING CHANGES. HE STUCK WITH IT,
AND MADE MUCH IMPROVEMENTS IN HIS SELF-ESTEEM AND SIGNIFICANT SPIRITUAL
INJURIES.

IN COMPARING J [REDACTED]'S SIGNIFICANT INJURY SCORE WHEN HE FIRST CAME INTO THE
SRS TO HIS EXIT SCORE ON LEAVING, THERE WAS MUCH IMPROVED OUTCOMES AS
FOLLOWS:

- 40% REDUCTION IN HIS FEELINGS OF GUILT.
- 20% REDUCTION IN HIS FEELINGS OF ANGER & RESENTMENT.
- 60% REDUCTION IN HIS FEELINGS OF DESPAIR, DOUBTS ABOUT GOD,
AND WORRY OR FEAR OF DEATH.
- 40% REDUCTION IN HIS FEELINGS OF LIFE OR GOD TREATING HIM
UNFAIRLY.
- 45% INCREASE IN HIS FEELINGS OF SELF-ESTEEM.

J [REDACTED] DEEPENED HIS SPIRITUALITY AND IT EMPOWERED THE REST OF HIS LIFE. HE
STATED THAT THIS EXPERIENCE HAD HELPED HIM, AND THAT HE FELT LIKE HE
HAD GROWN A LOT.

Signed by: /es/ EVERETT L WRIGHT
PROTESTANT CHAPLAIN 09/10/2001 13:34

[REDACTED] SHERIDAN, WY Printed:09/10/2001 13:34
B:10/15/1957 Pt Loc: RESIDENTIAL-SMI Vice SF 509

LEVEL 2 PERSONAL LOSS/LIFE CHANGE SCORE IS 126.
(97% OVER AVERAGE OF 64)
HAD PERSONAL INJURY, ILLNESS OR HOSPITALIZATION
HAD LOSS OF SELF-CONFIDENCE
HAD CHANGE IN ENERGY LEVEL
HAD CHANGE IN DRINKING BEHAVIOR
LEVEL 2 MARITAL RELATIONSHIP LOSS/LIFE CHANGE SCORE IS 0.

LEVEL 2 HOUSEHOLD LOSS/LIFE CHANGE SCORE IS 32.
(10% OVER AVERAGE OF 29)
HAD CHANGE IN RESIDENCE
HAD CHANGE IN NEIGHBORS/NEIGHBORHOOD

LEVEL 2 VOCATIONAL LOSS/LIFE CHANGE SCORE IS 75.
(168% OVER AVERAGE OF 28)
HAS QUIT JOB
HAS LESS JOB SECURITY

LEVEL 3 - COMPLEX SPIRITUAL ASSESSMENT

THE TOTAL SPIRITUAL INJURY SCORE IS 29.
(21% OVER HI THRESHOLD OF 24)

ADDITIONAL SIGNIFICANT SPIRITUAL INJURY(S):
FEELS DESPAIR OR HOPELESS
WORRIES ABOUT DOUBTS OR DISBELIEF IN GOD
WORRIES ABOUT OR FEARS DEATH

THE TOTAL PERSONAL LOSS/LIFE CHANGE SCORE IS 330.
(68% OVER AVERAGE OF 196)

HAD CHANGE IN EATING HABITS
HAD CHANGE IN SEXUAL ACTIVITY
HAD CHANGE IN SLEEPING PATTERN
HAS CONSIDERED SUICIDE
HAD CHANGE IN RELATIONS WITH PARENTS
HAD CHANGE IN RECREATIONAL TIME/ACTIVITY
HAD CHANGE IN TIME SCHEDULE
HAD CHANGE IN DRUG USE

THE TOTAL MARITAL RELATIONSHIP LOSS/LIFE CHANGE SCORE IS 0.

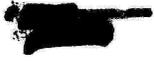
THE TOTAL HOUSEHOLD LOSS/LIFE CHANGE SCORE IS 32.
(24% UNDER AVERAGE OF 42)

THE TOTAL VOCATIONAL LOSS/LIFE CHANGE SCORE IS 75.
(SAME AS AVERAGE OR THRESHOLD)

THE TOTAL FINANCIAL LOSS/LIFE CHANGE SCORE IS 38.
(46% OVER AVERAGE OF 26)

HAD CHANGES IN FINANCIAL STATE
THE TOTAL LOSS/LIFE CHANGE SCORE IS 475.
(28% UNDER HI THRESHOLD OF 660)

HAS PATIENT CONSIDERED SUICIDE IN THE LAST TWO YEARS? YES
HAS PATIENT EXPERIENCED PHYSICAL/SEXUAL ABUSE IN THE LAST TWO YEARS? NO



Summary from Log

MEDICAL RECORD

Progress Notes

NOTE DATED: 07/27/2001 09:11 CHAPLAIN MULTILEVEL SPIRITUAL ASSESSMENT
 ADMITTED: 07/16/2001 10:18 RESIDENTIAL-SMI
 SUMMARY: PT COMPLETED SPIRITUAL ASSESSMENT LEVELS ONE THROUGH THREE.
 ASSESSMENT PRINT-OUT DEMONSTRATES THAT PT HAS A MIXED AMOUNT OF SPIRITUAL
 SUPPORT FROM THE FOLLOWING SUPPORT SYSTEMS (IN ORDER OF IMPORTANCE):

- +1. A GOOD AMOUNT OF SUPPORT FROM THE NON-ORGANIZATIONAL (DEVOTIONAL) SYSTEM. NOR SCORE IS 9 (13% OVER LO THRESHOLD OF 8)
- 2. A POOR AMOUNT OF SUPPORT FROM THE ORGANIZATIONAL (FAITH-GROUP) SYSTEM. ORA SCORE IS 7 (12% UNDER LO THRESHOLD OF 8)
- 3. A MINIMAL AMOUNT OF SUPPORT FROM THE INTRINSIC (PERCEPTION) SYSTEM. IRS SCORE IS 7 (42% UNDER AVERAGE OF 12)

PT'S SOURCES OF HELPS IN HIS SPIRITUAL LIFE ARE:

- 1. PRAYER: PERSONAL/GROUP
- 2. SACRAMENTS/ORDINANCES/CREEDS

PT'S SOURCES OF VALUES IN HIS SPIRITUAL LIFE ARE:

- 1. FRIENDSHIP
- 2. INNER HARMONY
- 3. GOOD HEALTH

ASSESSMENT REFLECTS THAT PT MIGHT USE HIS DEVOTIONAL SPIRITUALITY TO ASSIST HIS HEALTH CARE.

SPIRITUAL LOSSES OR SPIRITUAL LIFE CARE CHANGES OVER THE PAST YEAR ARE:

- 1. CHANGE IN RELATIONSHIP WITH GOD.
- 2. CHANGE IN CHURCH ACTIVITY OR PRAYER LIFE
- 3. SPIRITUAL EMPTINESS
- 4. CONSTANT FEELING OF GUILT OR ANXIETY

PT LISTED HIS SPIRITUAL PREFERENCE AS LATTER-DAY SAINTS

*PT CONSIDERED SUICIDE IN THE LAST TWO YEARS.

*PT DID NOT EXPERIENCE PHYSICAL OR SEXUAL ABUSE IN THE LAST TWO YEARS.

INTERVENTIONS:

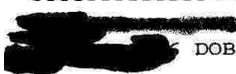
RECOMMEND VETERAN ATTEND THE SPIRITUAL RECOVERY SUPPORT GROUP MEETING TO WORK ON HIS SIGNIFICANT SPIRITUAL INJURIES OF:

- 1. GUILT
- 2. ANGER OR RESENTMENT
- 3. DESPAIR
- 4. DOUBT OR DISBELIEF IN GOD
- 5. WORRY OR FEAR OF DEATH

LOCATION: BUILDING 5 SOUTH, 2nd FLOOR, ROOM 219

Signed by: /es/ EVERETT L WRIGHT

PROTESTANT CHAPLAIN 07/29/2001 07:43



SHERIDAN, WY

Printed: 07/29/2001 07:43

DOB: [REDACTED] Pt Loc: RESIDENTIAL-SMI

Vice SF 509

Outcome Data for Spiritual Recovery Support Group

Significant Spiritual Injuries*

Substance Abuse Patient Population

	Guilt			Grief			Anger			Hopelessness			Loss of Purpose			Disbelief in God			Fear of Death			Unfair Treatment			Total # of Spiritual Injuries per Patient
	Initial Score	Final Score	% Imp	Initial Score	Final Score	% Improved	Initial Score	Final Score	% Improved	Initial Score	Final Score	% Improved	Initial Score	Final Score	% Improved	Initial Score	Final Score	% Improved	Initial Score	Final Score	% Improved	Initial Score	Final Score	% Improved	
A	100	40	60	80	40	40	100	40	60	80	40	40	80	60	20	80	40	40	80	40	40	80	40	40	1
B	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	6
C	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	3
D	100	80	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	2
E	100	60	40	100	60	40	100	60	40	100	60	40	100	60	40	100	60	40	100	60	40	100	60	40	3
F	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	1
G	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	2
H	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	3
I	100	60	40	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	4
J	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	2
K	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	1
L	80	40	40	80	40	40	80	40	40	80	40	40	80	40	40	80	40	40	80	40	40	80	40	40	3
M	80	40	40	80	40	40	80	40	40	80	40	40	80	40	40	80	40	40	80	40	40	80	40	40	3
N	80	40	40	80	40	40	80	40	40	80	40	40	80	40	40	80	40	40	80	40	40	80	40	40	3
O	80	40	40	80	40	40	80	40	40	80	40	40	80	40	40	80	40	40	80	40	40	80	40	40	3
P	100	80	20	100	80	20	100	80	20	100	80	20	100	80	20	100	80	20	100	80	20	100	80	20	2
Q	100	60	40	100	60	40	100	60	40	100	60	40	100	60	40	100	60	40	100	60	40	100	60	40	4
R	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	1
S	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	4
T	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	80	60	20	1
Total Patients with this spiritual injury	16			13			6			9			4			1			1			2			Average # of Spiritual Injuries/Patient
Improvement Score	29			29			37			33			40			60			60			40			3

*Patients who answered "very often" or "often" in multi-level spiritual assessment questions.

Substance Abuse Cases

Outcome Data for Spiritual Recovery Support Group			
Substance Abuse Patient Population			
Patient Self Esteem			
Pt. ID	Initial Score	Final Score	% Improved
A	0.225	0.8	58%
B	0.375	0.725	35%
C	0.575	0.75	18%
D	0.275	0.975	70%
E	0.4	0.65	25%
F	0.25	0.85	60%
G	0.55	0.835	29%
H	0.55	0.725	18%
I	0.375	0.625	25%
J	0.45	0.625	18%
K	0.5	0.85	35%
L	0.25	0.875	63%
M	0.3	0.8	50%
N	0.325	0.85	53%
O	0.2	0.775	58%
P	0.275	0.5	23%
Q	0.5	1	50%
R	0.2	0.55	35%
S	0.225	0.675	45%
T	0.625	0.95	33%
Improvement Average			40%

Sub Abuse Cases

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PAGE

NATIONAL CHAPLAIN CENTER
“BEST PRACTICE”
APPLICATION

GRIEF
PROCESS
GROUP

Ch. Theodore L. Bleck, D. Min.
Ch. Joseph McAfee, M. Div.
Ch. Robert F. Searle, M. Div.
Ch. Gary W. Bauch, M. Div.

Veterans Affairs Healthcare Network
Upstate New York at Canandaigua
400 Fort Hill Ave.
Canandaigua, NY 14424
585-393-7877

VA CHAPLAINCY BEST PRACTICES

Submitting Facility Location: Canandaigua (NY) VAMC

VISN Number: 02

PRACTICE DESCRIPTION

Please answer all questions as appropriate.

1. Title of Practice: **GRIEF PROCESS GROUP**

2. Description of Practice: *(Describe the practice. Include the following, as appropriate: What is done, who does it, how it is done, what materials, equipment, and/or facilities are used.)*

The Grief Process Group was initially developed in the spring of 1999 and implemented by September of that year. The initial group was open enrollment with over 214 individuals referred to the group over a 20-month time span. An assessment instrument was developed to determine the need and appropriateness on patients being referred to the group. It was discovered that the assessment instrument was successful in identifying that patients were in greatest need of group support for grief and bereavement issues. The clinical staff reported that the assessments were helpful in planning, documenting and summarizing treatment.

3. Responsible Office: *(Office responsible for implementation and administration of the practice.)*

Chaplain Section, Diagnostics & Therapeutics Care Line, with assistance from Behavioral Health Care Line, Geriatrics & Extended Care Line, Medical VA Care Line.

4. Purpose: *(Enter a brief purpose of the practice, i.e., why the practice was created.)*

Spiritual Assessments using the Berg Computerized Spiritual Assessment Profile revealed numerous patients reporting high Life Change/Loss scores (that included incidents of recent deaths of loved ones and friends) coupled with identification of “Sadness and Grief” as a spiritual injury. It was believed that a significant patient base existed to support a spiritually based group could be developed to assist in resolving grief and bereavement issues.

5. Scope of the Practice: *(Describe types of employees and/or patients who benefit from the practice; and who contribute to performing the program/practice, i.e., physicians, human resource staff, surgical or medical subspecialty patients, community organizations, veteran service organizations etc.)*

The Grief Process Group was designed specifically for inpatients enrolled in Substance Abuse treatment. It is readily adaptable to other populations including outpatients, long term care patients and staff support. It has been transported to the outpatient setting at the Rochester VA Outpatient Clinic with plans to expand the concept to the Syracuse VAMC.

6. Method of Implementation: *(Enter a description of the method of implementation.)*

- a. **Secure cooperation of allied services including Behavioral Health, Medical and Long Term Care to identify patients with potential grief and bereavement issues.**
- b. **Secure funding from VA Voluntary Services (VACO Advance Special) for printed materials.**

- c. **Locate and secure appropriate space to insure confidentiality for group participants.**
- d. **Publicize time, date and location of group session(s)**
- e. **Notify patients of their potential enrollment.**
- f. **Complete Grief Severity Assessments and document in the patient medical record results and/or enrollment in the group.**

7. Critical Success Factors: *(Describe any successes of the practice.)*

- a. **Patients enrolled in Grief Process Group are appropriate and in need of treatment for grief and bereavement issues**
- b. **Patients receiving treatment in the Grief Process Group demonstrate reduction in losses perceived as significant, reduction of symptoms and/or reduction in perceived severity of grief reaction.**

8. Barriers and Obstacles to Implementation: *(Describe any barriers and/or obstacles of the practice.)*

- a. **Lack of space**
- b. **Lack of cooperation from other clinical services**
- c. **Lack of cooperation from Voluntary Service**

9. Lessons Learned: *(Describe any lessons learned during the process of the practice.)*

- a. **There is a significant need for support for patients experiencing grief and bereavement**
- b. **A time limited approach can be effective in producing positive outcomes for patients in a few as 4 sessions and across as many as 9 sessions.**

10. Implementation Start Date: Month: **June** Year: **1999**

11. Measurable Outcomes: *(Are there measurable outcomes? Select Yes or No) (In the explanation, provide measurable data if available.)*

a. **(Yes) Patient Treatment Outcomes**

(If yes, please explain how Patient Treatment Outcomes have improved, providing measurable data if available.)

See attached description of program for details. Of the initial group of patients enrolled in the modified Grief Process Group 20% cited a reduction in the number of deaths perceived as significant or issue prone; 50% reported a reduction in symptoms, 75% reported a reduction in perceived grief severity.

b. **(No) Workforce Performance:**

(If yes, please explain how Workforce Performance has improved, providing measurable data if available.)

N/A- however, group work by chaplains is cost effective, vis-à-vis individual counseling, for grief and bereavement issues; the assessment process insures that patients truly needing treatment are enrolled in the group.

c. **(No) Employee Morale:**

(If yes, please explain how Employee Morale has increased, providing measurable data if available.)

N/A – though the chaplains involved in leading the group report an increased job satisfaction with the perception that patients enrolled in the Grief Process Group are truly in need of

treatment and that the treatment is successful in meeting the patients' needs arising out of grief and bereavement issues.

d. **(Yes) Customer Satisfaction:**

(If yes, please explain how Customer Satisfaction has improved, providing measurable data if available.)

In implementation of Grief Process Groups at Canandaigua VAMC and the Rochester VA Outpatient Clinic has been perceived positively by staff from other departments, most notably from Behavioral Health (including Substance Abuse Services), Home Base Primary Care and Medical VA Care Line. The group is seen as filling a specific need for support for veterans who have experienced a loss and are having difficulty with grief and bereavement issues.

e. **(Yes) Other:**

(If yes, please explain using any other measurable outcomes.)

See attached description of program outcomes. Data has validated that time-limited interventions provided in a 5 session format is successful in resolving significant grief issues.

12. How are you collecting or planning to collect data to evaluate the outcomes of implementation?
(Database/Hand Collected/Other) (If other, please explain or provide other data collection comments.)

Data consists of a pre- and post-participation Grief Severity Questionnaire, any related consultation or referrals from clinicians.

13. Implementation Resources Required:

- a. Materials/Supplies/Equipment: **\$ 400.00 (printed materials including CareNotes and other handouts)**
- b. Staff Education/Training Costs: **\$ 150.00 – \$500.00 (Certification as Grief Facilitator - optional)**
- c. **Total Implementation Costs: \$ 550.00 – \$900.00**
- d. **Recurring Costs: \$ 150.00/year materials replacement**
- e. **FTEE Required for Program: 0.1 FTEE (2-4 hours/week/group)**
- f. **Length of Time Required to Implement Program: 3 Months (Total number of Months)**

14. Attached are supporting documents, i.e., reports, customer service plans, policies, surveys, etc.
(Yes - No) Please list attachments:

15. Additional Information or Comments:

See attached documentation.

CONTACT INFORMATION:

16. Name: **Theodore L. Bleck** Title: **Network Lead Chaplain** Mail Routing Symbol: **500/125**

58 Grief Process Group

Commercial Phone:(585) 393-7886 Extension: N/A

Signature of facility D&T Care Line Manager

Signature of VISN D&T Care Line Manager

Signature of VA facility Director

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GRIEF PROCESS GROUP

Theoretical Framework:

Grief and bereavement work have been associated with pastoral and spiritual care from time immemorial. Religious rite and practice appear universal across cultural boundaries and historical eras. While other disciplines have staked claims to the field treatment of grief, chaplains retain a prominent role in the care for the bereaved. As one researcher noted,

“Grief demands ritual. To die alone is bad enough, but to die without rituals that lift the broken heart is worse. Those whose grief is affirmed within a wider community of faith are fortunate. (K. Woodward: 1997)

Chaplains can facilitate resolution of grief and bereavement through traditional rites and rituals. “...(T)he rituals that possess the greatest healing power are those not solely of our own invention. When death is absorbed into a liturgy that affirms transcendent life, something more than grief finds expression. The experience is called communion.” (K. Woodward: 1997)

The professional chaplain, however, can provide other critical clinical interventions.

- **Spiritual assessments such as the Berg Computerized Spiritual Assessment (CAP) and Grief Severity Assessment (below) can help identify unresolved grief issues as barriers to wellness.**
- **Patients can be connected to a wider sense of community through individual and group pastoral care interventions.**

“Grief is an isolating emotion,” observes James Campbell, professor of philosophy at the Rochester Institute of Technology. “When we grieve, we want to run away and hide, and that’s not a good way to handle grief.” (K. Woodward: 1997)

- **Pastoral counseling is a potential intervention.**

“Pastoral counseling is another excellent way to help residents, family, and staff better understand the grief process. People often look to religion as a means of coping with loss, so facilities might consider engaging a local member of the clergy as a grief counselor.” (Kavanaugh: 1995)

- **The professional chaplain can also facilitate staff in dealing with patient and personal bereavement issues which arise out of care for the dying. While Kavanaugh refers to a social services staff person, the role described below could well be fulfilled by a chaplain.**

“Administrators should consider designating a social services staff person to spearhead a program for addressing family and staff grief. Periodic in-service training on the grieving process can help staff better with family members who have lost -- or are about to lose – a loved one, as well as assist staff to cope better with their own feelings of loss or helplessness. The social service staff person should be available to counsel family members during one-on-one visits of formal group sessions.” (Kavanaugh: 1995)

People can grieve over losses other than by death. While grief is normally associated with emotional reaction related to death of a friend or loved one. (Head 1989) It is increasingly recognized that other losses such as divorce, separation or ended relationships are just as painful as losses due to death. (Williams: 1997) In addition any major change in life, even one perceived as good or positive, can elicit a grief and bereavement reaction. (Head: 1989) Again, there is a role for the professional chaplain in assisting the resolving grief and bereavement issues related to these types of losses. Williams notes that “Grief, at least, had some rules or rituals. Separation and divorce threw you into a maelstrom of energy sapping confusion.” (M. Williams: 1997)

Belief and Bereavement:

Recent research suggests that there is a positive relationship between Spiritual Belief and the ability to resolved grief and bereavement issues. In a cohort sample of over 100 patients research revealed that “people with low strength of belief resolved their grief more slowly during the first nine months but by 14 months had caught up with people with strong beliefs. Participants with no spiritual beliefs had higher grief scores than the remainder at the one-month and 14-month follow-up points.” The study suggests that “spiritual beliefs may provide an existential framework in which grief is resolved more readily,” and that “strength of belief affected the course of bereavement, independently of psychological status.” (Walsh: June 2002) If the research is accurate, it supports a more active involvement by the subject matter expert, the chaplain, in facilitating grief and bereavement work.

Advantages of use of support groups:

The professional chaplain is usually pressed for time given the demands experienced and the staff available. Pastoral care in a group setting presents the advantage of concentrating the efforts of the chaplain while maximizing the number of patients that can be served. Bousman suggests that additional benefits can be experienced by the patient:

- Temporary support system is provided,
- Answers to common questions are readily available in the experience of others in the group, and
- Patients receive help by no longer feeling alone (G. Bousman: 1996)

Wolfelt suggests that grief work is oriented to the following tasks that the mourner needs to accomplish.

- To experience and express outside of oneself the reality of the death
- To tolerate the emotional suffering that is inherent in the work of grief while nurturing oneself both physically and emotionally
- To convert the relationship with the deceased from one of presence to a relationship of memory.
- To develop a new self-identity based on a life without the deceased.
- To relate the experience of loss to a context of meaning.

These tasks can be facilitated in a group setting by providing an “action-oriented outlook of the grief experience as opposed to a perception of grief as a phenomenon they simply experience in a passive manner.” (Wolfelt: 1995)

Advantages of the use pastoral counseling as a treatment modality:

Pastoral counseling appears to represent a preferred treatment modality. Grief and bereavement are often mistakenly treated as depression. The typical symptoms of depression compared with complicated grief include:

Typical Symptoms of Depression:	Typical Symptoms of Complicated Grief:
Sadness	Unwillingness to accept death
Pessimism	Stunned
Lethargy	Numbed
Apathy	Disbelieving
Insomnia	Fearfulness
Guilt	Obsessional Thoughts
Hypochondriacal	Yearning for dead person
Complaints Persisting > 2 months after death	

Overlap between the symptoms of depression and complicated grief was found to be surprisingly small.

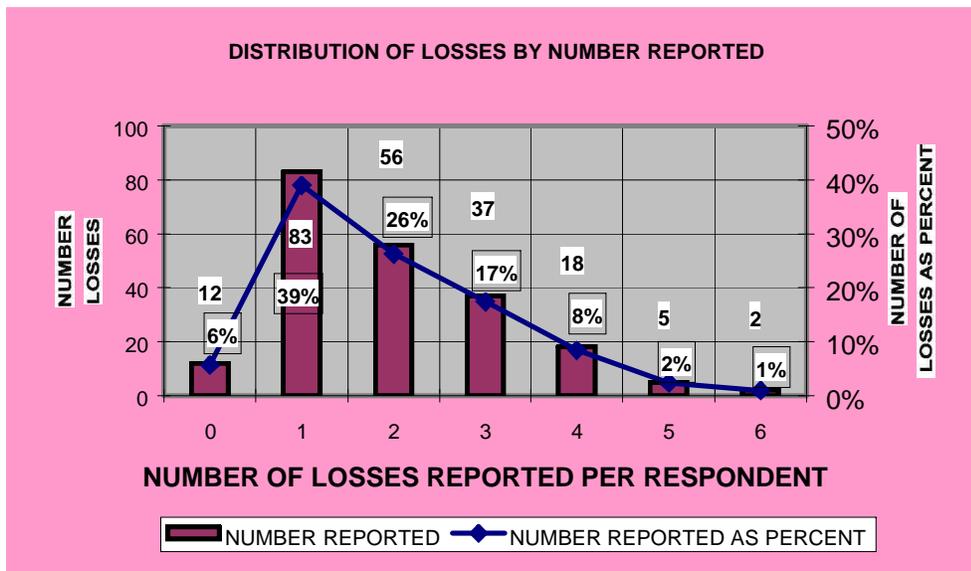
Milton Viederman observes that “depression requires a psychotherapeutic and psychopharmacological approach, whereas grief lends itself to the support of a responsive ear.” (Bower: 1995) Research cited in the Harvard Mental Health Letter noted Antidepressant drugs had little effect on complicated grief even when they helped to relieve depressive symptoms. Further the research suggests that depression may be more easily addressed while complicated grief is more persistent.

“Eighteen Months after the original interview, people who had been suffering from complicated grief were more likely to show signs of depression, anxiety, insomnia, low self-esteem, and poor overall functioning. People who had been depressed at the first interview had more medical illness, but were otherwise better off.” (Harvard Mental Health Letter, June 1995)

DATA SUMMARY RESULTS:

Data from the 214 Grief Severity Assessment questionnaires collected between September 1998 and July 2000 was collated and analyzed. Each participant in the Grief Process Group was asked to indicate the significant losses experienced over a 2 to 5 year period. While asked to indicate only the relationship (e.g., parent, spouse, friend, etc.) and the date of the loss, many respondents also indicated name of the person lost and occasionally multiple losses in a single category. This suggested either a simplification of the instrument or enabling the respondent to indicate multiple losses.

TABLE 1 – DISTRIBUTION OF LOSSES BY NUMBER REPORTED

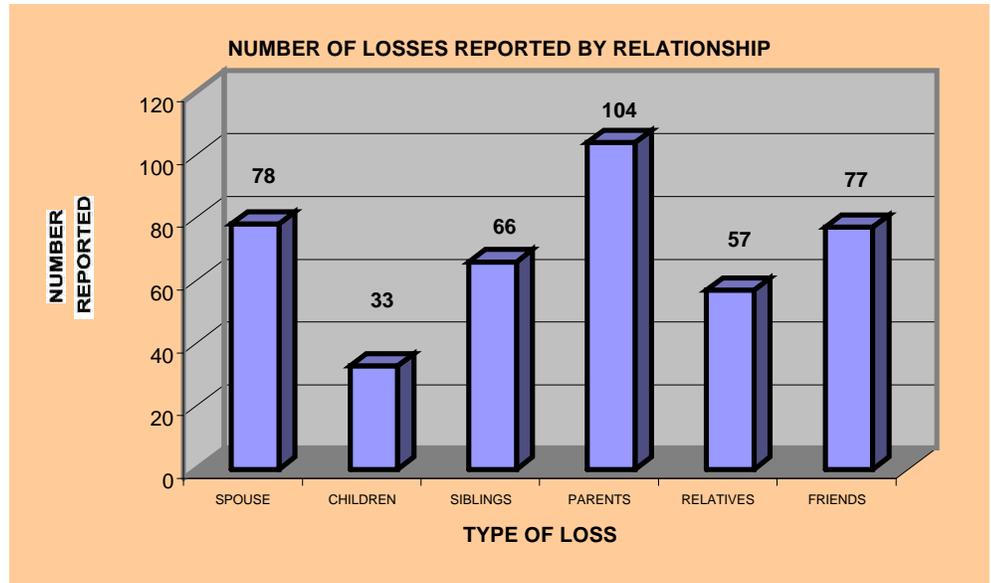


1. A review of the data showed that 12 participants (6%) indicated no loss by death of a family member or close friend. These all reported significant loss in other areas of life such as loss of job or housing. Those reporting only one loss of significance accounted for 39% of the respondents. Those reporting only one loss were the largest single group in the sample. However, 55% of those who attended the group indicated having experienced multiple losses of significant people in their lives.

Implications: Data suggests that while a significant number were attending due to single losses, the focus of the group would have to account for the majority having unresolved grief issues related to multiple losses. Further, a few were attending due to material losses instead of loss by death or separation.

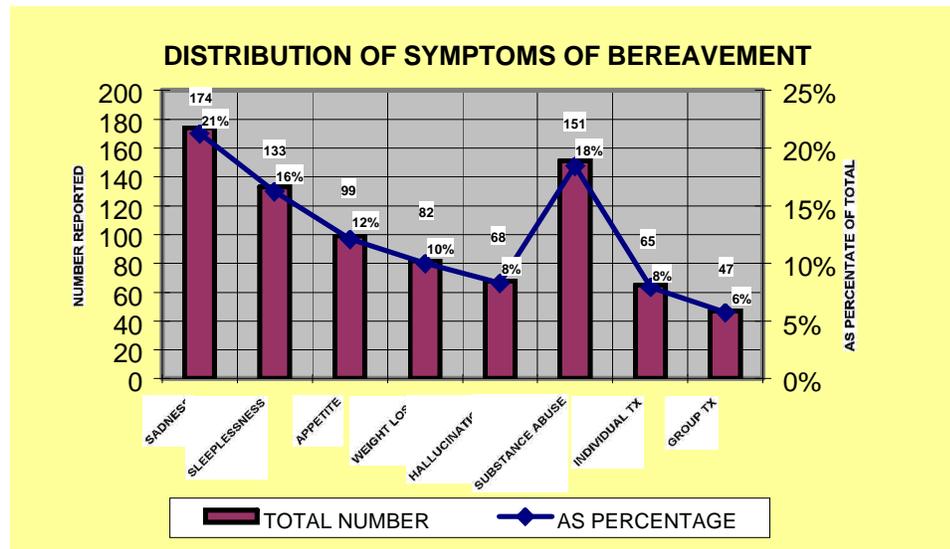
TABLE 2 – LOSSES REPORTED BY RELATIONSHIP

2. The respondents reported 415 distinct losses. A review of the data indicates that nearly half reported the death of one or both parents. The initial survey instrument did not differentiate between parent and grandparent since several participants indicated that primary parenting was provided by grandparents. The number of losses of parents and grandparents may be related to the age of the sample more than the significance the losses represent. The second and third most frequently cited losses were those related to spouse and close friend.



Implications: Further analysis of data should be done to determine the impact of the type of loss in terms of severity of bereavement. Loss of parents/grandparents may be utilized as a common point when encouraging participants to discuss losses. Loss of spouse and close friends represent relationships of choice rather than birth and may impact bereavement.

TABLE 3 – SYMPTOMS OF BEREAVEMENT



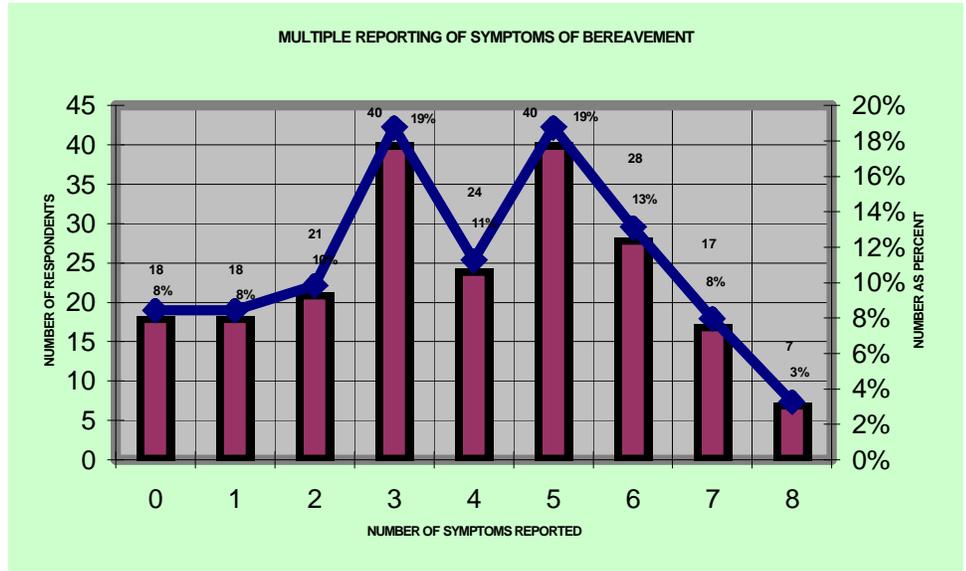
3. Eight symptoms of bereavement were identified in the DSM-IV. Participants were asked to identify which symptoms they had or were experiencing. Multiple selections were allowed. Three symptoms were identified by over half the respondents. These included overwhelming sadness, increased use of alcohol or drugs, sleeplessness (in order of frequency).

Several respondents also identified PTSD symptoms including dreams or nightmares.

Implications: If the Grief Process Group is successful in treating active bereavement, there should be a reduction in the number and frequency of reported symptoms between the pre- and post- test surveys. Further drug and alcohol use may be related to the population served in the initial sample rather than a true indicator for a more generalized population. Allowance for substance abuse issues needs to be made when creating a syllabus for group sessions and in the actual group process.

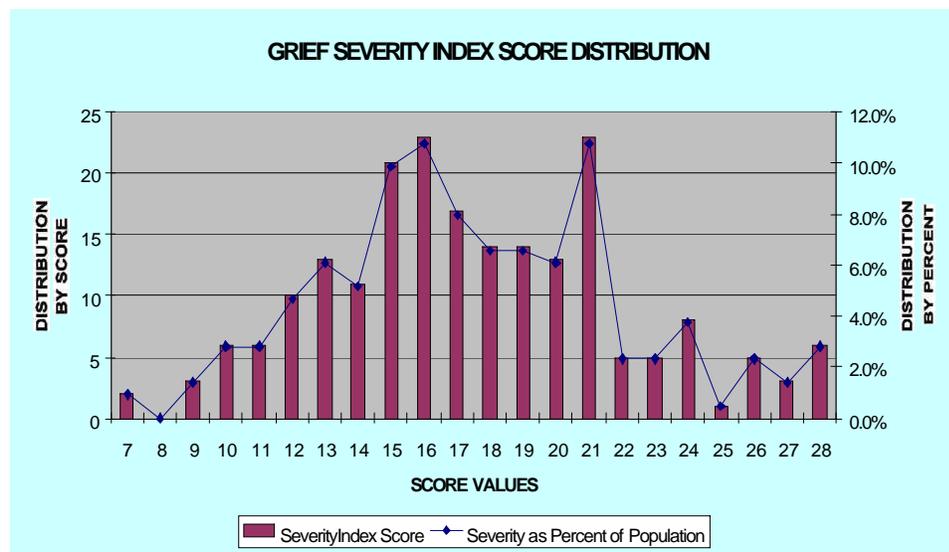
TABLE 4 – MULTIPLE REPORTING OF SYMPTOMS

4. The distribution of symptoms indicates that of the 213 respondents, 84% reported 2 or more symptoms. Nearly 50% (49%) of the respondents reported 3, 4 or 5 symptoms. The table may suggest that those reporting 3-4 symptoms are experiencing moderately severe bereavement, while those reporting ≥ 5 symptoms may show high severity in bereavement.



Implications: Threshold for limiting enrollment in the Grief Process Group to those reporting 2 or more could be established without severely restricting participation. If capacity could not handle the anticipated caseload, a threshold of ≥ 3 symptoms could be established and still serve 64% of the potential clients.

TABLE 5 – GRIEF SEVERITY INDEX SCORE DISTRIBUTION



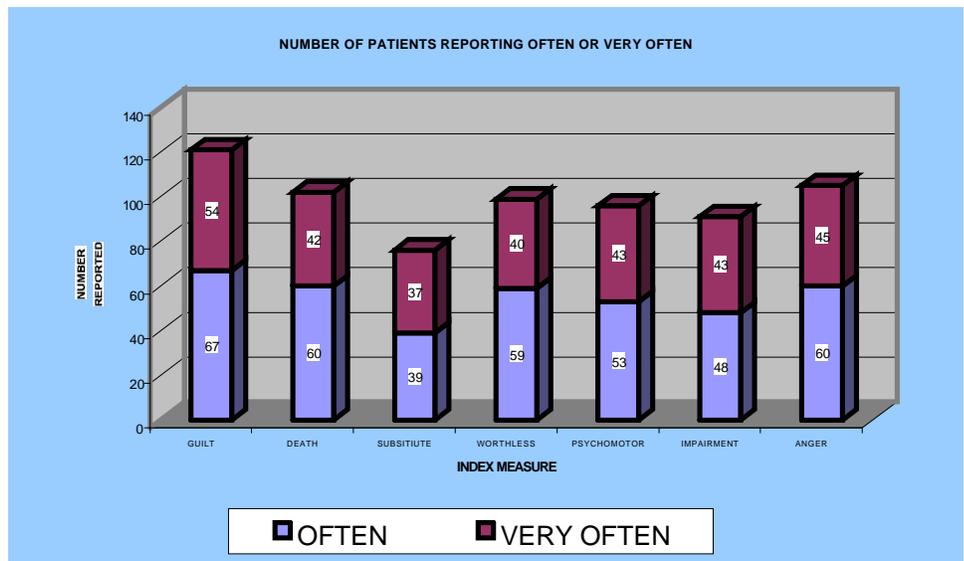
5. The Grief Severity Index is based on a 4 point Likert Scale requiring the respondent to select a response between “never,” “sometimes,” “often,” and “very often.” These were scored at a value of “1,” “2,” “3,” and “4” respectively. Scores can range from a total of 7 (all “never” responses) to 28 (all “very often” responses).

Distribution of scores suggests thresholds exist at score totals of 15-16 and 21.

Implications: Patient enrollment should be limited to those scoring 15 or above on the Grief Severity Index. Patients scoring 21 or higher on the scale may need additional support though either 1:1 counseling or additional group sessions.

TABLE 6 – INDEX MEASURE RANKED OFTEN OR VERY OFTEN

6. Patients were asked to rank seven measures on the Grief Severity Index Scale to indicate the intensity of grief reactions to losses. These measures included: Feelings of guilt, worthlessness, anger, awareness of one's own mortality, sense that one's abilities (cognitive and psychomotor) were impaired, and a sense that the respondent should have died in the place of the loved one or friend.



Only “often” and “very often” responses were counted. These were considered to be responses indicating significant problems for the patient.

In rank order, most to least, the respondents indicated difficulties with guilt, anger, awareness of one's own mortality, worthlessness, psychomotor impairment, cognitive impairment and thoughts of substitution in the place of the one who died.

These match observations of others in the field of grief and bereavement work. Bousman for example notes:

“Anger does not become a part of grief for every person but is common. Anger in grief is usually a secondary emotion following feelings of helplessness and the inability to change the situation.” (G. Bousman: 1996)

And,

“Guilt feelings among those who grieve are common. When we lose a loved one, we search for the reason it happened. When the reasons are not obvious we blame ourselves. This often fades as we move through the grief process, but it can linger and present unnecessary pain.” (G. Bousman: 1996)

Bower cites lowered self-esteem is a significant issue related to depression noting that current research supports “...Sigmund Freud's contention in a 1917 monograph that depression touched off by a loved one's death drags down self-esteem, whereas grief (or what Freud called mourning) does not. However, Freud, viewed grief as a uniformly healthy process, while Prigerson's group argues that it can sometimes take a virulent form. (Bower: 1995)

Van Baarsen links support resources such as bereavement groups to self-esteem:

“Support resources and self-esteem may supplement each other. Bereaved elderly individuals with low self-esteem seem to be more vulnerable not only when they receive little support from their network after partner loss, but also when they have a confidant...” (Van Baarsen: 2002)

Implications: The design of the 4 weekly sessions for the Grief Process Group should focus on the most frequently mentioned measures. The syllabus would be designed to deal with guilt, anger, mortality and self worth.

OUTCOME RESULTS

The first group consisted of 5 veterans identified by a response of “Often” or “Very Often” to the question “How often do you feel sad or experience grief?” on the Spiritual Injury Scale or scored above 1 standard deviation

above the mean for the Life Change/Loss Scale, or indicated experiencing a death of a friend or loved one within the past two years. A Grief Severity Assessment was completed to determine appropriateness for enrollment in the group. Four veterans were asked to complete a post-assessment following the end of the fifth session.

CHANGE IN GRIEF SYMPTOMS AND SEVERITY

Differential				
Group	# Sessions	Losses	Symptoms	Severity
1	2	0	-1	-2
1	3	NA	NA	NA
1	4	-4	-2	-1
1	5	2	1	4
1	5	0	-4	0

Only two of the patients attend all five sessions, one patient was discharged prior to the fifth session. Three of four participants reports an improvement in one or more areas assessed (one reported a reduction of the number of losses considered significant, three reported a reduction in symptoms, 2 reported a reduction in severity). One participant reported increased symptoms and severity. This was related to a domestic separation having been initiated while enrolled in the group. Each veteran was offered the opportunity to continue in the group for a second cycle of discussion topics.

Group	# Sessions	Losses	Symptoms	Severity
2	1	NA	NA	NA
2	4	0	1	-1
2	4	1	0	-3
2	5	1	1	3
2	8	0	-6	-2
2	8	0	0	0

Of the second set of patients, three were patients carried over from Group 1 and three were newly enrolled. Of the 6 patients, one attended only one session and did not complete a post-assessment. Two patients reported perceiving additional losses related to their grief issues. Two reported a slight increase in symptoms while one reported a significant decrease in symptoms. Most significant was that 3 (50%) reported a perception that their grief and bereavement was less severe. The one patient reporting increases in all areas measured related the increases to on-going separation and divorce proceedings.

Group	# Sessions	Losses	Symptoms	Severity
3	1	NA	NA	NA
3	2	0	1	0
3	4	1	1	-4
3	8	1	1	-2
3	8	0	1	-1
3	9	-1	-5	-3

The post-assessment results from the third group showed the most positive results in reducing perception of severity with 4 of 5 patient reporting lower scores. The increase in symptoms is a false positive due to a design flaw in the assessment instrument.

CHANGE IN GRIEF SYMPTOMS AND SEVERITY

Differential From Initial Assessment

Uniques #	Sessions	Losses	Symptoms	Severity
A	1	NA	NA	NA
B	1	NA	NA	NA
C	2	0	1	0
D	3	NA	NA	NA
E	4	-4	-2	-1
F	4	0	1	-1
G	5	1	1	3
H	8	2	2	-3
I	8	0	0	0
J	9	0	-6	-2

Of the patients completing both a pre- and post-assessment questionnaire, 4 of 7 (57%) report no change in their perception of the number of losses they perceived as significant, while 2 reported additional losses and 1 few losses. This would suggest that the perception of which losses are deemed significant tend to remain unchanged over time. Four reported an increase in symptoms, but this is a false positive since 3 of 4 (75%) indicated on the post-assessment they had sought help from participation in a support group as a result of their enrollment. OF greatest significance is the reported reduction in perception of severity of bereavement with 4 of 7 reporting less severity, 2 reporting no change and 1 reporting an increase in perceived severity. The one patient reporting an increase in perceived severity was actively engaged in separation and divorce proceedings throughout his enrollment.

Conclusions:

1. The perception of which losses are significant to patients remains relatively unchanged in the course of treatment,
2. Symptoms can be reduced since increases can be attributed to a design flaw in the assessment instrument, and
3. Participation in grief process group can reduce the perception of severity with a minimum of 4 to 8 sessions.

Follow-up:

Following the end of the third group cycle revisions to the Grief Severity Assessment were made (see Grief Severity Assessment Ver. 3.0 below) with the addition of symptoms of complicated grief and separating out utilization of counseling and support groups. Handouts are being redesigned to make them more visually appealing. Finally, the Grief Process Group has been transported to the outpatient clinic setting and Rochester VA Outpatient Clinic, with plans to initiate a similar group at the Syracuse NY VAMC.

GRIEF ASSESSMENT QUESTIONNAIRE (ver. 2.0)

Name: _____
 SSN (last 4): _____
 Date: _____

I have experienced the following loss(es) through death, divorce or separation in the past:

✓	Relationship	Date of loss	Date of loss
	Spouse		
	Child or grandchild		
	Brother or sister		
	Parent or step-parent		
	Grandparent		
	Other relative		
	Close friend		
	Significant material loss		

Following the loss of my friends or loved ones I experienced

✓	Check All That Apply
	Overwhelming sadness/depression
	Difficulties in sleeping
	Change in appetite
	Weight loss/Weight gain
	Visual or auditory sense that the departed was with me
	Increased use of alcohol and/or drugs
	Sought help through professional counseling
	Sought help through a support group

Whenever I think of the losses I have experienced:

1. I feel guilty over things I did or failed to do.
 Never
 Sometimes
 Often
 Very Often

2. I have thoughts about my own death.

- Never**
 Sometimes
 Often
 Very Often

3. I feel like it should have been me who died.

- Never
- Sometimes
- Often
- Very Often

4. I feel worthless.

- Never
- Sometimes
- Often
- Very Often

5. I feel like things around me are moving faster than I can go.

- Never
- Sometimes
- Often

Very Often

6. I have difficulty accomplishing simple things in my daily life.

- Never
- Sometimes
- Often
- Very often

7. I feel more angry or resentful.

- Never
- Sometimes
- Often
- Very Often

COMMENTS:

Veterans Affairs

Department of **Memorandum**

Date: January 14, 2002

From: Sr. Chaplain (500/125)

Subj: Grief Process Group

To: Behavioral Health Care Line Manager (300)

Chaplain Section has rescheduled the Grief Process Group and is seeking referrals from providers and treatment teams in the Behavioral Health Care Line.

CRITERIA FOR INCLUSION IN GROUP:

- Significant loss by death of a relative or friend within the past two years, or
- Has verbalized difficulty in resolving grief resulting from a loss by death of a friend or loved one greater than two years prior, or
- Experiencing exacerbation of grief symptoms due to anniversary of loss by death.
- Experienced other significant losses (e.g., housing, job, relationship, etc.)

THERAPEUTIC MODEL

- Closed Group (patients must be referred and assessed for grief severity)
- 4 sessions
- Kubler-Ross “Five Stages of Death and Dying” (cognitive model)
- Utilization of veteran’s own religious, philosophical, and spiritual resources (spiritual model)
- To increase awareness of the relationship between unresolved grief and behavioral health management

ENROLLMENT IN GROUP:

- Unresolved grief or bereavement issues identified by assessment process(es)
- Issues identified by multidisciplinary treatment care planning
- Consultation request by primary care provider to Chaplain Service

MATERIALS:

- **CARENOTES/PRAYERNOTES** are available for distribution to veterans and are purchased through Chaplain Section, D&T Care Line and General Post Funds.
- **INFORMATIONAL BROCHURE** is underdevelopment for use by primary care providers.

GROUP TIMES, LOCATIONS AND FACILITATORS:

VAMC CANANDAIGUA

Tuesdays, 2:00 PM

D&T Conference Room

Building 8, basement, Room 13

Facilitators: Ch. Theodore L. Bleck

Ch. Joseph R. McAfee

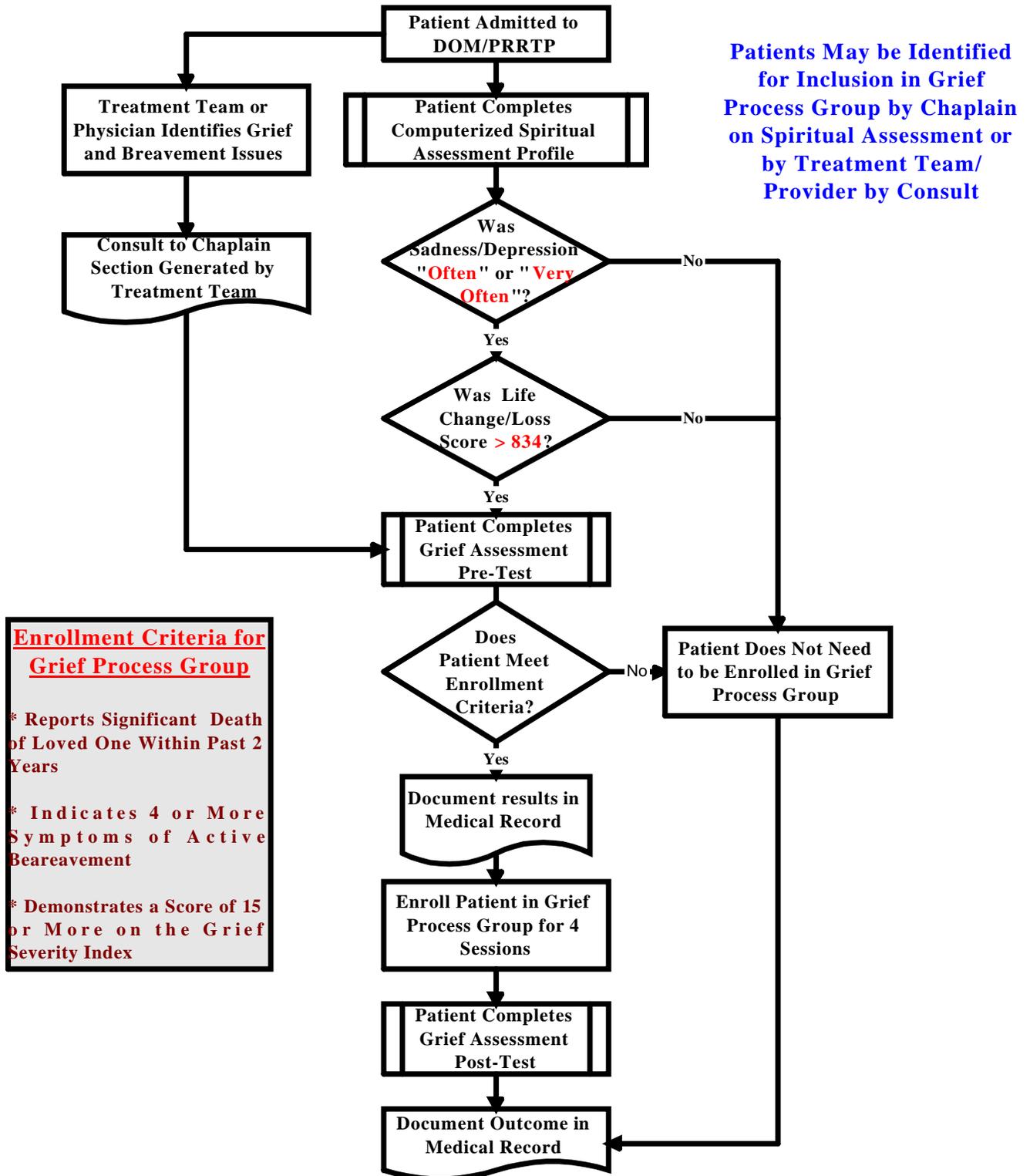
The initial session will be held March 5th. Please refer patients as soon as possible.

Theodore L. Bleck, D. Min.

CLINICAL PRACTICE GUIDELINE

GRIEF AND BEREAVEMENT CARE

ALGORITHM



SESSION 1: NAMING OUR LOSSES

Didactic outline:

- Models of Grief and Bereavement from A. Wadeley, "The Mourning After"

**Table 1 Symptoms of Grief
(Adopted from Stroebe & Stroebe, 1987)**

Affective	Depression, anxiety, guilt, anger, hostility, anhedonia, loneliness
Behavioural manifestations	Agitation, fatigue, crying, sighing
Attitudes towards the self, the deceased and the environment	Self-reproach, low self-esteem, helplessness and hopelessness. Feelings of anger towards the deceased or of being let down or betrayed. Sense of unreality, suspiciousness, interpersonal problems
Cognitive impairment	Retardation of thought and concentration
Physiological changes and bodily complaints	Disruption of appetite, sleep patterns and bodily rhythms, loss of energy, aches and pains, palpitations, nausea/vomiting, shortness of breath. Physical complaints of the deceased. Changes in drug-taking, including alcohol, increased susceptibility to illness and disease

**Table 2 Stages of Dying
(Kubler-Ross, 1969)**

Denial	The person resists facing death and may seek other professional opinions or reassurance from religion.
Anger	The person ask, 'Why me?'" and may feel hostile, resentful and envious of others; there may also be a strong feeling of frustration over unfinished business
Bargaining	When 'Why me?' is not answered, bargains may be struck with God or fate; many bargains will be made and broken
Depression	Denial becomes impossible, hospitalization may be necessary, there may be physical deterioration and a great sense of loss as well as guilt and worry about letting others down
Acceptance	In this 'final rest before the long journey', the dying person may feel resolute, although not happy

**Table 3 Stages of Grieving in the Person Facing Bereavement
(Fulton, 1970)**

Depression	Accompanied by extreme upset and anticipatory grief
Heightened concern	For the ill person, accompanied by the need to deal with unfinished business and discuss things with the dying person. Caring well for them at this point can help to obviate guilt when the person dies
Rehearsals for the death	Developing coping strategies
Adjustment to the consequences	New coping strategies along with those developed at stage three can help here

**Table 4 Stages of Grieving After the Death Has Occurred
(Murray-Parkes, 1972)**

Initial response	Shock, disbelief, extreme sorrow, numbness, coldness and emptiness.
Coping	Anxiety and fear about breaking down completely. The person may turn to tranquillizers, sleeping pills or alcohol, and may show a number of physical and psychological symptoms; these will become more sporadic in the first year or so
Intermediate phase	Characterised by obsessional reviews ('I could have done more'), trying to explain the loss ('It was God's will') and searching for the presence of the deceased through reminiscing and revisiting certain places
Recovery phase	In about the second year, a more positive attitude may develop, even pride at having survived the crisis and grown through it

- What to expect (WORKING THROUGH GRIEF: SELF CARE HANDBOOK)
 - Shock and disbelief: a typical first reaction; nature's way of protecting.
 - Anger or resentment: death of a loved one may seem to be an injustice; places a blame on others (doctors, nurses, God).
 - Guilt: an awareness of unfinished business, lost opportunities, errors in judgment, personal relief at the death of a loved one.
 - Fear: awareness of personal sense of mortality; feeling like going crazy; worries about impending problems.
 - Deep Sadness: sense of emptiness; reliving other losses; deep yearning; loneliness.
 - Physical problems: weight loss/gain; tiredness; lack of appetite/nausea; colds/illness.
 - Hope and personal growth: increased empathy for others; renewed confidence in self; expanded interests and relationships.
- How one has handled grief related to losses in the past is a good indicator of how one will handle more recent loss.
- Grief is nature's emotional velcro – what has gone before frequently is added to the present sense of loss.

Questions for Group Discussion:

- What losses have you experienced in the past? More recently?
- How have you coped with your sense of loss in the past?
- How are you coping with your sense of loss today?
- What have you found to be helpful in dealing with loss?

Out of group exercise/reflection:

- Make a list of the significant losses you have experienced in your life (most recent to least recent). Leave room to write a paragraph or two between each.
- Write how you feel right now about each of the losses you have listed.

SESSION 2: DEALING WITH GUILT

- Guilt is a companion to grief
- Some deaths invite guilt feelings:
 - Death of a child you were supposed to protect
 - Sudden death of a close friend or relative and no chance to say good-bye
 - Suicide you were “unable to prevent”
 - Death following a lengthy illness in which you provided limited care giving
 - Combat or accidental death in which you felt powerless to help
- Feeling guilty and being guilt are not the same thing
 - had you realized what you were doing, you might have acted differently
 - no one has 20/20 vision
- Accept your humanity- and your loved one's
 - We are not perfect
 - We are meant to learn from the past
 - Our loved ones are not perfect
- Make peace with your feelings
 - Don't insist on feelings being logical
 - Listen to your feelings
 - Feelings are neither good nor bad
 - Avoid thoughts of “if only”
 - Acknowledge feelings of abandonment
- Seek reconciliation
 - Make amends to damaged relationships
 - Use the prayers and rituals of reconciliation of your faith tradition
 - Make apologies to the person you mourn
 - Write a letter
 - Visit the gravesite
- Give yourself credit
 - Replay the scenes that haunt you and try to see other ways of dealing with them
 - Focus on the good times recalling times when you were fully attentive and loving

SESSION 3: DEALING WITH ANGER

GRIEF

Grief is a normal response and natural reaction to loss, separation or alienation.

How we deal emotionally with the significance of the event is paramount.

How we face the situation helps us see what stage of progression of Grief we are in (or regression).

ANGER

Anger is a most definite and defined state.

The loss was unfair and unjust.

To many times anger causes the same outcome, more anger.

Anger myths

It's o.k. to feel angry only if we can justify our feelings

It is a sin to feel anger

Anger means hate

It means we are loud and defensive

We have to strike out at something or someone

Punish those who punish us

Whoever does to us, break from them.

Someone else is responsible

Anger is wrong

Good people don't get angry

Add 5 to the list

- 1.
- 2.
- 3.
- 4.
- 5.

Truths about anger.

Anger is energy

It is a common emotion

It hurts the holder

Sobriety is not a cure for anger

Most people have no place to take their anger

Add to the list

- 1.
- 2.
- 3.

We can direct anger toward?

- | | |
|-------------|----|
| 1. self | 1. |
| 2. job | 2. |
| 3. God | 3. |
| 4. spouse | 4. |
| 5. children | 5. |

a. What could have made a difference?

b. How could changing the event have affected the outcome of your anger?

1. Anger limits our interest and can become a focus.
2. Hatred/Anger is the destroyer of peace of mind and happiness.
3. Only problems allow us to examine solutions and work on patience and tolerable acceptance.
 - a. I am angry for what someone did.
 - b. I am angry for why they did it.
 - c. I am angry for how it was done.
 - d. I am angry for when it was done.
 - e. I am angry for the way it was done.
 - f. I am angry for who did it.

The Power of Compassion, a collection of lectures by his holiness the XIV Dalai Lama
Thorson, 1981, Harper Collins Publishers 77-85. Fulham Palace Road, Hammersmith, London W68 JB

1.

2.

3.

SESSION 4: DISCOVERING RENEWED SELF WORTH

To often the way we think about our self worth and value is based on the experiential learning process of life which might have many negative unresolved issues and events protruding outwardly like sharpened poles protecting the fort.

- I. In order to feel of worth and value there must be
 - A. Human affection and understanding
 - B. Positive interaction with others
 - C. The ability to look beyond ourselves in some spiritual sense
 - D. Feel a part of something of continued source and strength

- II. Self Worth
 - A. Historical evidence should not be used to limit personhood
 - B. Remember potential is always waiting to be transformed into confidence and awareness
 - C. No one has the right to impose or force his or her beliefs on another person (Buddhist teaching)

- III. It should be human nature to use responsible judgment in order to utilize the total being of oneself.
 - A. If we give out love, compassion and kindness we hope to get it returned.
 - B. If we do not receive fulfillment we should recognize that this situation or event is negative.

Positive interaction brings satisfaction with life.

Question: What must I do to feel of worth and value?

Question: When did I last feel of worth and value?

Question: What is of greatest value to me?

SESSION 5: A TIME OF REMEMBRANCE AND CLOSURE

Psalm 90 Of God and Man

[1] O Lord, you have always been our home.

**[2] Before you created the hills or brought the world into being,
you were eternally God, and will be God forever.**

[3] You tell man to return to what he was; you change him back to dust.

**[4] A thousand years to you are like one day;
they are like yesterday, already gone, like a short hour in the night.**

**[5] You carry us away like a flood; we last no longer than a dream.
We are like weeds that sprout in the morning,**

[6] that grow and burst into bloom, then dry up and die in the evening.

[7] We are destroyed by your anger; we are terrified by your fury.

[8] You place our sins before you, our secret sins where you can see them.

[9] Our life is cut short by your anger; it fades away like a whisper.

**[10] Seventy years is all we have— eighty years, if we are strong;
yet all they bring us is trouble and sorrow; life is soon over, and we are gone.**

**[11] Who has felt the full power of your anger?
Who knows what fear your fury can bring?**

[12] Teach us how short our life is, so that we may become wise.

**[13] How much longer will your anger last?
Have pity, O LORD, on your servants!**

**[14] Fill us each morning with your constant love,
so that we may sing and be glad all our life.**

**[15] Give us now as much happiness
as the sadness you gave us during all our years of misery.**

**[16] Let us, your servants, see your mighty deeds;
let our descendants see your glorious might.**

**[17] Lord our God, may your blessings be with us.
Give us success in all we do!
Having A Heart Of Wisdom.**

1. Everyone in our lives has contributed to our life experience.
2. Think back to those who you have lost and what they have contributed to your life experience.
3. Write down three things you wish to take from the experience of knowing each of the significant people you mourn.

Name	Name	Name

4. As you light a candle in memory of those you have lost, mention one or more of the things you are going to take with you and make a part of your life.

Final Version of Grief Severity Assessment

GRIEF ASSESSMENT QUESTIONNAIRE (ver 3.0)

Name: _____

SSN (last 4): _____

Date: _____

Talking with others about an experience of loss is difficult at best. However, taking a moment to answer the following questions will help us understand your sense of loss better.

Please take a moment and mark the responses which describe your experiences and feelings.

I have experienced the following loss(es) through death, divorce or separation in the past:

	Relationship	Comments
	Spouse	
	Child or grandchild	
	Brother or sister	
	Parent or step-parent	
	Grandparent	
	Other relative	
	Close friend	
	Significant material loss	

Following the my losses I experienced:

	Check All That Apply
	Overwhelming sadness or depression
	Frequent episodes of crying or sighing
	Feelings of helplessness or hopelessness

	Difficulties in sleeping
	Increased tiredness or fatigue
	Change in appetite
	Weight loss/Weight gain
	Visual or auditory sense that the departed was with me
	Feelings that things are not real
	Increased anxiety or agitation
	Heightened sense of loneliness
	Increased use of alcohol and/or drugs

	Sought help through professional counseling
	Sought help through a support group

Whenever I think of the losses I have experienced:

- Sometimes
- Often
- Very Often

1. I feel guilty over things I did or failed to do.

- Never
- Sometimes
- Often
- Very Often

COMMENTS:

2. I have thoughts about my own death.

- Never
- Sometimes
- Often
- Very Often

4. I feel like it should have been me who died.

- Never
- Sometimes
- Often
- Very Often

4. I feel worthless.

- Never
- Sometimes
- Often
- Very Often

5. I feel like things around me are moving faster than I can go.

- Never
- Sometimes
- Often
- Very Often

6. I have difficulty accomplishing simple things in my daily life.

- Never
- Sometimes
- Often
- Very often

7. I feel more angry or resentful.

- Never

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Note: A catalogue of products is available. Pamphlets are affordable when purchased in bulk. Titles do change and availability of specific titles may vary.

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WORKING WITH TRAUMA RELATED GUILT IN THERAPY

By

Richard Davis

Over the last several of years I have been providing pastoral counseling for patients in mental health. An area of interest that has emerged during that time is in the area of trauma related guilt. It started when working with several of my PTSD patients who were admitted for self harming behaviors. Several of these patients were open about their guilt feelings and their attempt to harm themselves because of the guilt. I suppose their openness was a result of such deep pain that they could no longer contain the guilt. Since that time the requests for guilt debriefing has mushroomed. Many of my patients now ask for guilt debriefing as well as the ever increasing referrals from my mental health colleagues.

When working on guilt issues I begin by asking what the level of guilt is based on a 10 point scale and how often they feel guilty. This helps both the psychiatrist and me to understand the intensity and frequency of guilt feelings. At various points in the debriefing process I will ask the patient to tell me the level of their guilt and how often they feel guilty. This informs me about how well the interventions are working and if I need to add additional focus in an area. The intensity and frequency of guilt feelings is also important information for the psychiatrist to know since it can affect discharge plans. The guilt debriefing steps that I use are as follows.

- 1) A detailed non judgmental description of what happened. Who was involved? How much time was there to make decisions? Where everyone and what were they doing? What were you thinking and feeling at the time? What other forces influenced your decision?
- 2) Determining who the responsible parties were. What each party was responsible for. How much each party was responsible for.
- 3) Identify faulty thinking errors, unrealistic self talk and the role it plays, as well as how it perpetuates guilt feelings.
- 4) Replace unrealistic self talk with more reality based self talk that does not perpetuate guilt.

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