

*Reducing  
mental health  
disparities  
among  
rural veterans*

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## INSIDE THIS ISSUE

Identification and Treatment of Spiritual Injury in Mental Health	Pg. 1
The Guide to Mental Health Services for Veterans & Families	Pg. 3
SC MIRECC Recruitment Strategies Survey	Pg. 4
Upcoming Conference Calls	Pg. 4
Recovery Corner	Pg. 5

The next issue of the South Central MIRECC Communiqué will be published February 3, 2011. Deadline for submission of items to the December newsletter is January 28, 2011. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Ashley McDaniel, at [Ashley.McDaniel@va.gov](mailto:Ashley.McDaniel@va.gov)

South Central MIRECC Internet site:  
[www.mirecc.va.gov/visn16](http://www.mirecc.va.gov/visn16)

National MIRECC Internet site: [www.mirecc.va.gov](http://www.mirecc.va.gov)

## IDENTIFICATION AND TREATMENT OF SPIRITUAL INJURY IN MENTAL HEALTH

By Bonita P. Barnes, M.Div., BCC  
Central Arkansas Veterans Healthcare System

*"Either you're running to God, grasping to hold on to the guy you were before you came to Iraq, or you're running right away from him because of what you're seeing." – George Schmidt, National Guardsman (Newsweek, May 5, 2007).*

*"I'm not supposed to see this, God. No person is supposed to see this. How can you let this happen?" – Charley Goddard (Paulsen, 2000)*

As these quotes show, combat affects our troops on deep levels. However, little information on spiritual injury is available. While anyone can experience the distress that spiritual injury causes emotionally, this article will address the effect of spiritual injury on Veterans who have returned from a combat zone. These basic principles can also be applied to any situation.

By acknowledging the mind,



Pictured: Chaplain Bo Barnes, M.Div., BCC

body, and soul connection, treatment can expose the underlying spiritual issues affecting Veterans. Spirituality revolves around meaning. Each person defines what spirituality means to him or her. Some people express their spirituality by being a part of a defined faith group that shares common beliefs, rituals, worldviews and worship. For others, spirituality is encountered in alternative beliefs.

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## *Identification and Treatment of Spiritual Injury in Mental Health continued...*

In either event, a person need not have a belief in the traditional view of God as presented in a certain religious tradition in order to experience a full and meaningful life.

Spiritual injury involves an interruption in the perception of meaning and purpose in an area or areas of life. As Mark LaRocca-Pitts (2004) writes in the *Harvard Divinity Bulletin*:

Spirituality is that which gives a person meaning and purpose and is found in relationships with self, others, ideas, nature, and, possibly, a higher power, or a wholly other. These many relationships are prioritized according to an organizing principle and form an intra-, inter-, and trans-relational web that houses a person's sense of meaning and purpose. Spiritual distress arises when one of these relationships that provide meaning is threatened or broken. The more significant a particular relationship or complex of relationships is, the greater the severity of spiritual distress if that relationship is threatened or broken. Spiritual wholeness is restored when that which threatens or breaks the patient's relational web of meaning is removed, transformed, integrated, or transcended.

How spiritual injury or distress is addressed by clinicians and clients determines whether or not the Veteran can use the internal conflict to bring about a positive change. With so many threatened or broken relationships in the life of combat Veterans, it is essential that a sense of the significance of life be recaptured. Kalman Kaplan, Ph.D., and Elizabeth Jones, M.Div. (2010), approach this idea from the point of "living in a maximal way." When in combat the objective is clear, life and death are always on the edge. In coming home, life can appear to be superficial. Kaplan and Jones assert that part of healing is to "help create a sense of intrinsic meaning and excitement about other maximal experiences in life such as family and career."

The following is a partial list of spiritual concerns expressed by Veterans returning from a combat zone:

- **Image of God/Higher Power no longer the same** (*"I don't know who God is anymore or even if there is a God."*)
- **Guilt about breaking personal code of ethics/values** (*"Stuff happened there that really bothered me."*)
- **Despair that life can have meaning again** (*"I just want my life to be the way it used to be, but that ain't gonna happen."*)
- **Seeing self as beyond hope** (*"You just don't know what I did over there."*)
- **Doubting that forgiveness is possible** (*"I can never forgive myself for what I did." "How could God ever forgive me?"*)

To address this issue, a theologically educated, clinically trained person provides treatment. In the VA, this person is the chaplain. Chaplains are the experts in the area of treating spiritual injury. However, in settings with no chaplain available, such as a community-based outpatient clinic or other community setting, it can be difficult for the mental health professional to identify and address these spiritual needs. Furthermore, mental health providers may be uncomfortable discussing spiritual and religious beliefs and practices with clients. According to Saunders, Miller and Bright (2010), clinicians often have concerns about their scope of practice in having a conversation with a client that includes spiritual matters.

So, how do clinicians address spiritual injury within their professional boundaries? Mental health providers can identify spiritual injury and then take steps to refer the Veteran for appropriate treatment. To do this it is imperative that providers identify their own personal beliefs concerning spirituality and religion before addressing the issue with their patients. In this way, providers decrease the possibility that they will interpret the experience of the patient solely through their own subjective lens, which enables them to be more objective and present. Being able to come to a comfortable place within themselves helps providers incorporate a client's beliefs and practices in treatment to bring about improved health.

- **Loss of soul/self** (*"I don't know who I am anymore."*)

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Asking nonthreatening questions can help to ascertain the possibility of spiritual injury. Examples of these inquiries include:

- **To whom or what do you feel connected?**
- **When do you feel most alive and energized?**
- **Do you believe that you can survive this present crisis?**
- **Do you have someone with whom you can communicate freely?**
- **What or who is most important to you right now?**

All of these questions are related to meaning in life. In treatment, if clients talk about their spiritual beliefs and practices and those appear to be healthy and life giving, help them to utilize these resources in recovery.

In his book *War and the Soul*, Edward Tick (2005) states, “Unexpressed moral and spiritual conflicts as well as physical handicaps ensuing from the battlefield can all render Veterans ‘disabled’... They may cling to patriotic or religious platitudes for support rather than experience the loss of meaning that haunts them. And if they have the courage to face this loss, they confront a terrifying and painful social, moral and ontological chasm.” Spiritual

injury is all about loss of meaning. The goal is to help our Veterans reinterpret the meaning of their lives in light of what they have experienced.

**Visit the Ask the Expert section of the VISN 16 Mental Health Providers Community of Practice website from a VA computer at <http://vawww.visn16.portal.va.gov/SiteDirectory/mh/AsktheExpert/default.aspx> to submit your questions to Chaplain Barnes or participate in the article discussion group.**

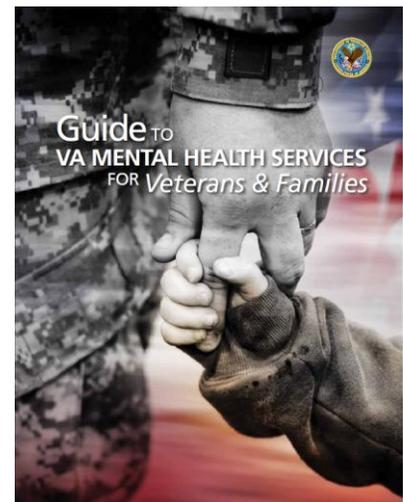
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## THE GUIDE TO VA MENTAL HEALTH SERVICES FOR VETERANS & FAMILIES

In 2008, the VA introduced a new mental health handbook that provides guidelines for VA hospitals and clinics across the US. The new handbook specifies the mental health services VA hospitals and clinics are required to offer Veterans and their families. While requirements differ depending on VA hospital or clinic size or type, they apply across the entire VA system. The SC MIRECC developed the *Guide to VA Mental Health Services for Veterans and Families*, a shorter, simplified version of the handbook intended for the general public.

The *Guide* was developed for Veterans and their family members, Veterans service organization members, or members of other groups interested in VA mental health care to describe what mental health services their local or regional VA health care facility has pledged to provide. It outlines the guiding principles of mental health care, explains how to find treatment, and describes VA treatment settings, such as hospitals, clinics, and telemedicine. It provides information about the types of treatments available for Veterans' most common mental health problems (e.g., depression, substance abuse, PTSD) and describes the special programs offered for particular groups of Veterans (e.g., women, homeless Veterans, or older Veterans). The appendix lists the mental health services VA hospitals and clinics are required to provide, and the glossary defines common VA mental health terms. A copy of the *Guide* can be accessed online at [www.mirecc.va.gov/VISN16](http://www.mirecc.va.gov/VISN16).



## SC MIRECC AND MIDAS NEED YOUR HELP!

### RECRUITMENT STRATEGIES SURVEY

Passage of the Health Insurance Portability and Accountability Act (HIPAA) in 1996 has had profound effects on human-participants research. For example, because diagnostic information is restricted to those who “need to know” for clinical or administrative purposes, Institutional Review Boards (IRBs) no longer permit research assistants (RAs) to approach patients in clinic waiting rooms about study participation. It is often challenging to identify strategies for making initial contact with potential participants that will be both effective and acceptable to local IRBs. These challenges are somewhat greater for non-clinician investigators and for studies that are population-based or involve OEF/OIF Veterans. However, they also affect clinician investigators as well as studies that are clinic-based and involve Veterans of any service-era.

Investigators tend to learn from one another which strategies generate the level of response needed to approach and recruit an adequate number of eligible individuals in a reasonable amount of time. Unfortunately, that is a fairly slow and imprecise learning process. Further, because IRBs are local and the acceptability of various strategies varies from facility to facility and over time, effective strategies that have been acceptable in one locale may be unacceptable in another.

SC MIRECC leadership believes a document summarizing experience to date would be a useful resource for human-subjects investigators throughout VISN 16. A document summarizing the strategies that

have and have not been effective, and have and have not been acceptable to local IRBs would provide the evidence needed to make choosing strategies and getting IRB approval for them simpler and more efficient. To that end, the MIRECC Implementation, Design and Analysis Support team (MIDAS) has been asked to survey VISN investigators and prepare a summary document.

Over the next 4-6 weeks, MIDAS will send a brief electronic questionnaire via Survey Monkey to SC MIRECC investigators and to a few investigators from outside VISN 16. The survey will ask about the methods investigators have used – or proposed to use – to make that first contact with potentially eligible Veterans. Principal Investigators can respond to the questionnaire themselves or have a project coordinator respond for them. MIDAS will compile the responses into an SC MIRECC report that will be distributed to respondents.

**Participation is voluntary, but MIDAS and SC MIRECC leadership hope those of you who receive a survey will take the time to respond to it – it will help not only you, but other investigators, SC MIRECC researchers, and our Veterans as well.**

For more information about the MIDAS Recruitment Strategies Survey, contact Dana Perry ([danamperry@earthlink.net](mailto:danamperry@earthlink.net)) or Ellen Fischer, Ph.D. ([FischerEllenP@uams.edu](mailto:FischerEllenP@uams.edu)).

<b>JANUARY CONFERENCE CALLS</b>		ACCESS
CALL-IN NUMBER: 1-800-767-1750		CODE
10	MIRECC Site Leaders, 11:00 AM CT	27761#
11	MIRECC Leadership Council, 3:30 PM CT	19356#
13	National MIRECC & COE Education Group, 1:00 PM CT	28791#
18	VISN 16 Mental Disaster Team, 11AM CT	76670#
19	MIRECC Program Assistants, 2PM Central	43593#
24	MIRECC Education Core, 3:00 PM CT	16821#
25	MIRECC Leadership Council, 3:30 PM CT	19356#
27	MIRECC & CoE Implementation Science Discussion, 1:00 PM CT	28791#

## RECOVERY CORNER

### RECOVERY IN VA MENTAL HEALTH & PTSD OUTPATIENT CLINICS

By Leigh Ann Johnson, LCSW  
Mental Health Recovery Coordinator  
VA Gulf Coast Veterans Health Care System

VA's are making great progress in promoting recovery through Psychosocial Rehabilitation and Recovery Centers (PRRC's), Mental Health Intensive Case Management Programs (MHICM), Residential Rehabilitation and Treatment Programs (RRTP's) and other services. Now recovery coordinators are exploring strategies to promote recovery transformation in VA mental health and PTSD outpatient clinics.

#### Why Focus on Mental Health & PTSD Outpatient Clinics?

Specialty mental health programs like PRRC and MHICM use psychosocial rehabilitation principles to promote recovery for Veterans with severe mental illness. These programs provide quality services and are more cost effective than inpatient acute care, but can only serve limited numbers of Veterans. Case in point, our PRRC and MHICM programs have a combined enrollment of less than 150 individual Veterans. Meanwhile, the National Psychosis Registry for FY 2009 listed VA Gulf Coast as serving 2459 Veterans. This figure does not include the additional number of Veterans without a diagnosis of psychosis treated by VA Gulf Coast for other mental health issues like bipolar disorder, PTSD and/or depression. Strategies are needed to promote mental health recovery with these Veterans.

While VA mental health clinics prepared for returning OEF/OIF Veterans, we also saw an increase in the number of new patients who served prior to 9/11. At the same time, many long-time patients with chronic mental illness continue to receive help. The flow of new patients is much greater than the flow of new mental health staff. Evidence-based treatment and recovery-oriented

practices are being used with new patients as they begin treatment. Time-limited specialty programs are structured to produce "graduations", but then these patient graduates usually transition into VA mental health outpatient and PTSD clinics that are already busy serving long-time patients. It has been difficult to help patients with chronic mental illness transition to levels of care outside the VA. Mental health outpatient and PTSD clinics need new strategies to increase treatment capacity while promoting recovery and community integration for Veterans of all service eras.

#### Needs of Veterans with Chronic Mental Illness:

Many Veterans with chronic mental illness have received VA services for years but may not yet have received evidence-based treatment. Most participate in medication management with a psychiatrist, physician's assistant, or nurse practitioner. At times, these Veterans may need counseling for relationship issues, financial situations, transportation problems, housing, etc. But at many VA's, only the small number of Veterans enrolled in MHICM, PRRC, or the U.S. Department of Housing and Urban Development and VA Supported Housing program have an assigned case manager. When Veterans do not have an assigned case manager, the medication prescriber may end up providing principal therapist duties for treatment planning plus supportive counseling and information and referral services. This leaves little time to work on recovery concepts. It might be more cost effective and efficient to restructure programs so that an MSW or Ph. D. level staff member can help with some of these tasks, perhaps using a group format. However, there is a shortage in the number of qualified staff available to run groups.



medication management with a psychiatrist, physician's assistant, or nurse practitioner. At times, these Veterans may need counseling for relationship issues, financial situations,

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### **Increasing Veteran Participation in Groups**

Many medication prescribers indicate they would like to see their patients participate in some form of talk therapy and/or support group because they have seen positive impacts on Veterans' overall functioning when they do participate in said treatments. However, staff report Veterans are frequently reluctant to enroll in groups due to concerns about privacy. Once Veterans do find and participate in a group, they rarely want to leave it. Some Veterans with chronic mental illness have participated in medication management supplemented by traditional therapist-led support groups for years. As a recovery coordinator, I have visited some of these groups to give presentations on mental health recovery. When asked what they like most about their groups, they rarely mention the therapist's expertise. Instead, they share how much they value the support they receive from other Veterans in the group. In talking with them it also seems there are many who still need help developing a meaningful quality of life outside the VA. New Veterans continue to join but few ever graduate. This "pooling" of the in/out flow makes it difficult as more and more therapists are functionally needed. As a solution to this issue, peer-led support groups have been recommended as a new level of care for Veterans, which can functionally increase treatment capacity.

### **Peer Support in the Mental Health & PTSD Outpatient Clinics**

Some VA's have established paid positions for peer support specialists, while others are developing volunteer peer support programs. Over a year ago, the Biloxi mental health and PTSD clinic staff began working with a number of Veterans to develop Veteran-led support groups, and tried many options. Group One consisted of Veterans who had participated as a cohort in numerous psychologist-led groups and later were helped to graduate by that psychologist. They were not happy about graduation but began meeting on their own out in the community with great success. I began holding consultation sessions with key leaders from Group One along with Veterans from a second group that could no longer meet at the VA due to staffing issues. Our goal was to help the second group learn how to replicate the success of Group One. We reviewed peer support facilitation materials from numerous sources, discussed strengths and challenges faced by Group One, explored the needs of the second group, and obtained meeting space in the community. No member of the second group would agree to become a facilitator, but a member

of Group One agreed to do so. Next, we held a Peer Support Kickoff at the VA for the second group. We provided food; invited members of Group One to share their stories; introduced the peer facilitator for the second group; discussed the community meeting location; solicited input, answered questions, allowed time for fellowship; etc. While the turn out from the second group was great for the Kickoff at the VA, none of the participants ever came to the community-based location. The facilitator went there week after week, made phone calls, etc. but with no success. At the same time, Group One continues to thrive and grow, recruiting new members themselves, as well as receiving referrals from VA staff. So what made the difference? We believe the level of recovery education Veterans received during therapist-led support groups had a profound impact on their motivation to participate later in a peer-led support group. Another key factor was the level of group cohesion established during VA-provided treatment groups that helped them transition to the community peer-led support group.



### **Ideas for Promoting Recovery**

VA mental health and PTSD outpatient clinics can increase treatment capacity by providing phased, time-limited groups based on varying levels of care. Orientation classes can be helpful in promoting a culture of recovery among new patients, but traditional therapist-led support groups also need modification to promote recovery among long-time patients. It is essential for therapists to pre-load recovery concepts into existing cohorts of Veterans. Changing providers and topics along the way while keeping cohorts intact can increase Veterans' ability to support one another after each provider moves on to new duties. Clinicians can promote recovery by helping Veterans develop a new sense of personal mission and identity. This includes a self-assessment of strengths, values, preferences, and dreams, as well as goal setting. Groups can also discuss ideas for giving back to others as part of recovery. But more therapists are needed to offer such services. And similar to the pre-loading concept noted above, forethought and design should be emphasized when developing treatment clinics and clinical training programs so that transitional care can be more easily implemented. At VA Gulf Coast, we are in the process of coordinating transitional or staged groups as a way to promote cohesion and increase likelihood of additional successes like Group One.

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With respect to training, we are pre-loading recovery concepts in our facility's APA approved Psychology Internship Program. Likewise, during the fall of 2011, VA Gulf Coast will begin its Rural Mental Health Postdoctoral Fellowship program, led by Scott A. Cardin, Ph.D. Staff Psychologist, Director of Psychology Training VA Gulf Coast Veterans Health Care System. (For more information contact [Scott.Cardin@va.gov](mailto:Scott.Cardin@va.gov)) Dr. Cardin and I will be working with the new postdoctoral fellows and other VA staff to expand and pre-load recovery-oriented treatments in the mental health and PTSD outpatient clinics.

### New Ideas for Peer Support

The sheer volume of Veterans served in mental health and PTSD outpatient clinics requires exploration of new models of peer support based on grassroots approaches. The Public Health field uses various peer support mechanisms for health promotion and chronic disease management. These community-based models involve partnerships with local government, schools, civic groups, and faith communities. The VA could use similar strategies for collaboration with stakeholders. In rural communities, many biker clubs already include Veterans, promote service to others, and provide peer support. Biker clubs participate in service projects, help

Wounded Warriors in their community, and partner with VAs for events like Stand Down. Mental health staff can increase opportunities for patients to link with these existing community supports. Here are just a few national websites with contact information on local chapters:

- Patriot Guard Riders:  
[www.patriotguard.org](http://www.patriotguard.org)
- Combat Veterans Motorcycle Association: <http://combatvet.org/>
- Vietnam Vets Motorcycle Club:  
<http://www.vnvmcfreedom.com/>
- Christian Motorcyclists Association:  
<http://www.cmausa.org/>

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## RURAL HEALTH RESOURCES UPDATE

### Rural Hospital Support for Emergency Medical Services (Final Report)

This study uses Medicare Hospital Cost Reports to identify rural hospitals, with and without Emergency Medical Services (EMS) units, to answer the following questions: what proportion of rural hospitals support or operate EMS units; has this changed in last five years; what are the characteristics of rural hospitals that support or operate EMS; what are the financial investments made by these hospitals in EMS; and what describes the communities in which these hospitals are located. For more information, contact: Victoria Freeman, RN, DrPH, North Carolina Rural Health Research and Policy Analysis Center, Phone: 919-966-6168, [victoria\\_freeman@unc.edu](mailto:victoria_freeman@unc.edu). To download a copy of this report, visit [http://www.shepscenter.unc.edu/research\\_programs/rural\\_program/pubs/report/FR100.pdf](http://www.shepscenter.unc.edu/research_programs/rural_program/pubs/report/FR100.pdf).

### Rural Health Snapshot 2010

The Rural Health Snapshot displays selected indicators of access to health care, health behavior/risk factors, and mortality rates, comparing rural to urban residents. For more information, contact: Victoria Freeman, RN, DrPH, North Carolina Rural Health Research and Policy Analysis Center, Phone: 919-966-6168, [victoria\\_freeman@unc.edu](mailto:victoria_freeman@unc.edu). To download a copy of this report, visit [http://www.shepscenter.unc.edu/research\\_programs/rural\\_program/pubs/other/RuralHealthSnapshot2010.pdf](http://www.shepscenter.unc.edu/research_programs/rural_program/pubs/other/RuralHealthSnapshot2010.pdf).