U.S. Department of Veteran Affairs

Veterans Health Administration
Veterans Integrated Service Network 22

Promoting Recovery, Resilience and Suicide Prevention with Holistic and Spiritually Integrated Treatments: Taking Care of Our Veterans and Ourselves

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There are no financial or other conflicts of interest by the author of this document and the items represented within the presentation.

Project 22

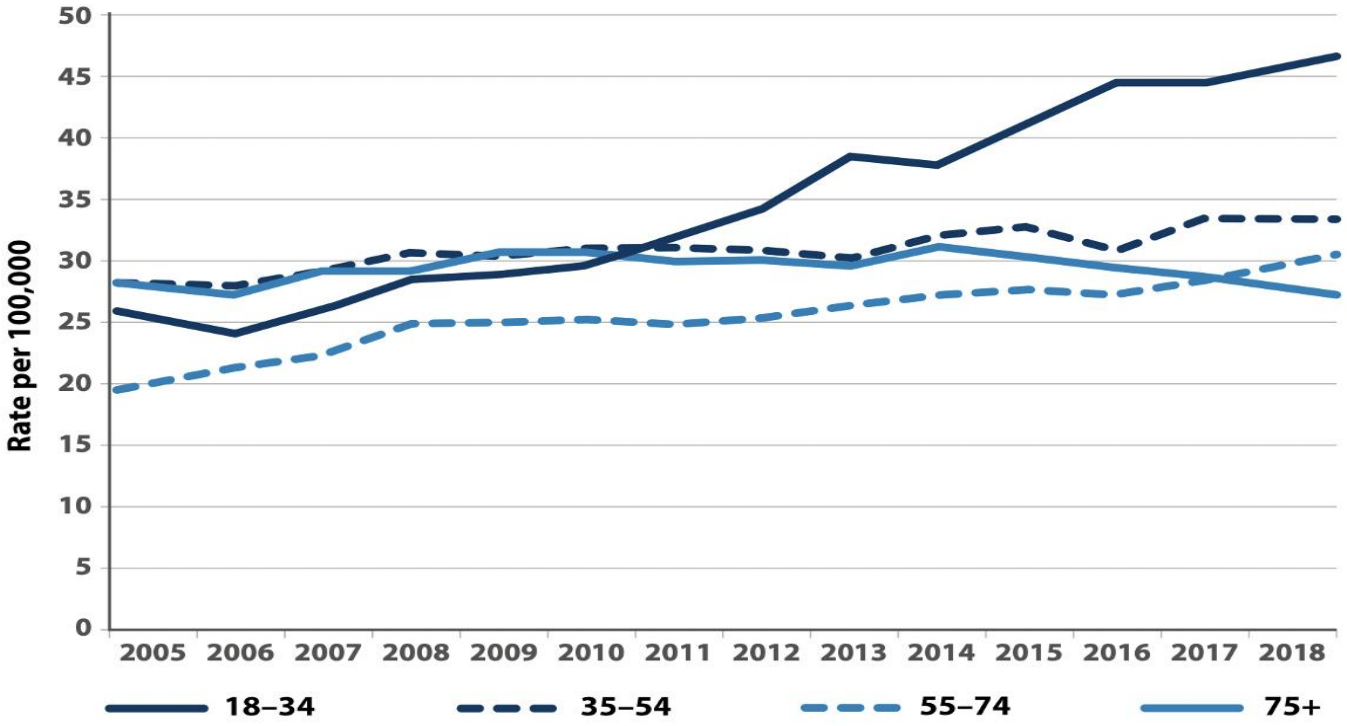
- 22 Veterans committed suicide each day of 2013
- Movie about and by Veterans raising awareness for high numbers of suicides in Veterans(Egbert & King, 2015)

Recovery and Suicide Prevention

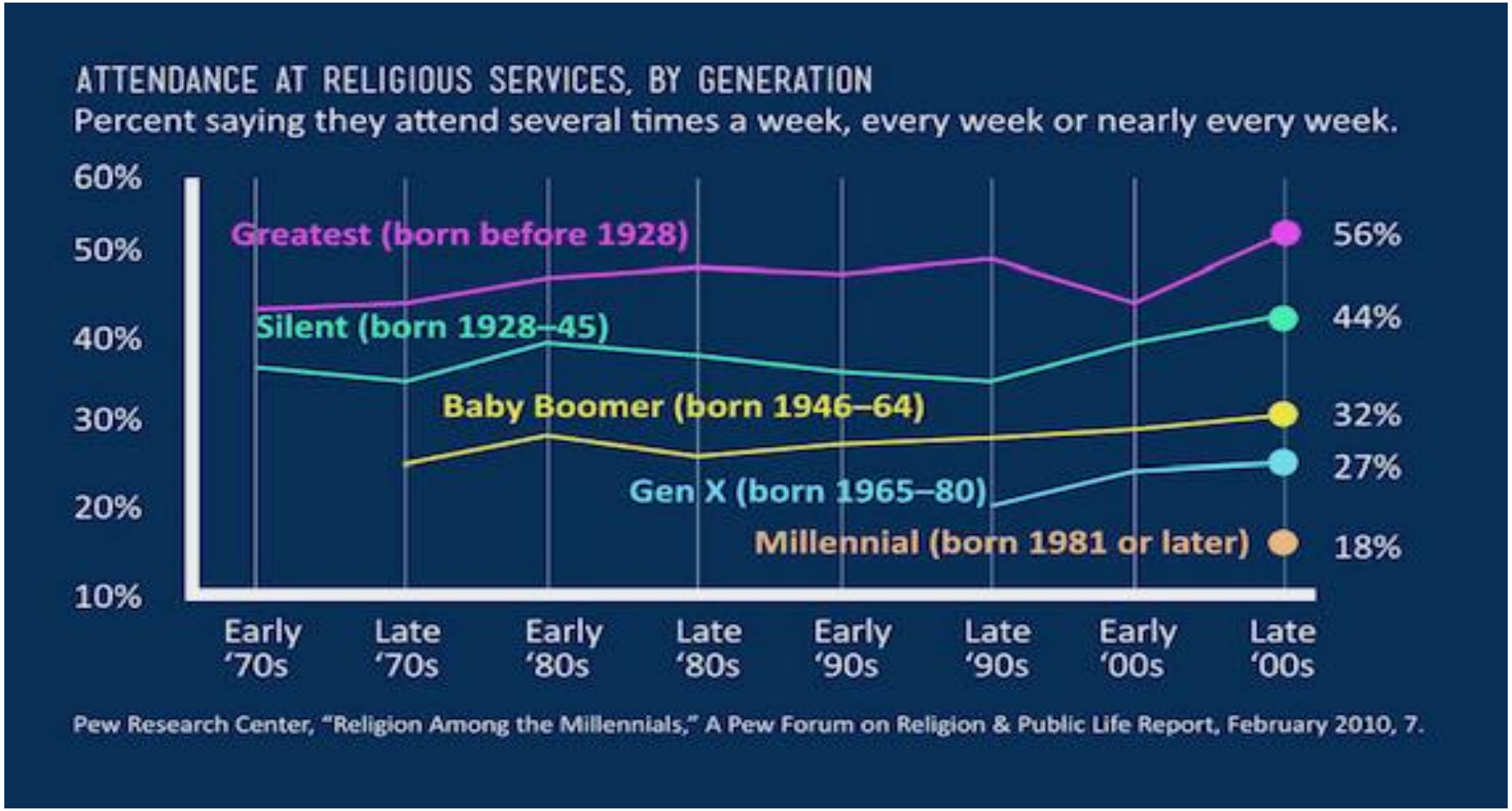
- There is a need for better treatments that offer greater hope of recovery (Koenig et al., 2018; Steenkamp et al., 2015). Medications are NOT the go to treatment for PTSD, and "evidence-based treatments" are not necessarily acceptable to all Veterans.
- VA has mandated the recovery model for serious mental illness—different than the medical model, it is patient centered and includes a holistic approach/multi-disciplinary.
- Recovery embraces the notion that people with serious mental illness can live meaningful lives Happiness is a byproduct of living a meaningful life (Viktor Frankl, Man's Search for Meaning.)
- "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential." (SAMHSA, 2006)

Rates of Veteran Suicide

Graph 5. Veteran Suicide Rates, by Age Group and Year, 2005–2018



Religious Service Attendance



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Religious Service Attendance and Deaths from Despair

JAMA Psychiatry | Original Investigation

Religious Service Attendance and Deaths Related to Drugs, Alcohol, and Suicide Among US Health Care Professionals

Ying Chen, ScD; Howard K. Koh, MD, MPH; Ichiro Kawachi, MD, PhD; Michael Botticelli, MEd; Tyler J. VanderWeele, PhD

IMPORTANCE The increase in deaths related to drugs, alcohol, and suicide (referred to as *deaths from despair*) has been identified as a public health crisis. The antecedents associated with these deaths have, however, seldom been investigated empirically.

OBJECTIVE To prospectively examine the association between religious service attendance and deaths from despair.

DESIGN, SETTING, AND PARTICIPANTS This population-based cohort study used data extracted from self-reported questionnaires and medical records of 66 492 female registered nurses who participated in the Nurses' Health Study II (NHSII) from 2001 through 2017 and 43 141 male health care professionals (eg, dentist, pharmacist, optometrist, osteopath, podiatrist, and veterinarian) who participated in the Health Professionals Follow-up Study (HPFS) from 1988 through 2014. Data on causes of death were obtained from death certificates and medical records. Data analysis was conducted from September 2, 2018, to July 14, 2019.

EXPOSURE Religious service attendance was self-reported at study baseline in response to the question, "How often do you go to religious meetings or services?"

MAIN OUTCOMES AND MEASURES Deaths from despair, defined specifically as deaths from suicide, unintentional poisoning by alcohol or drug overdose, and chronic liver diseases and cirrhosis. Cox proportional hazards regression models were used to estimate the hazard ratio (HR) of deaths from despair by religious service attendance at study baseline, with adjustment for baseline sociodemographic characteristics, lifestyle factors, psychological distress, medical history, and other aspects of social integration.

RESULTS Among the 66 492 female participants in NHSII (mean [SD] age, 46.33 [4.66] years), 75 incident deaths from despair were identified (during 1 039 465 person-years of follow-up). Among the 43 141 male participants in HPFS (mean [SD] age, 55.12 [9.53] years), there were 306 incident deaths from despair (during 973 736 person-years of follow-up). In the fully adjusted models, compared with those who never attended religious services, participants who attended services at least once per week had a 68% lower hazard (HR, 0.32; 95% CI, 0.16-0.62) of death from despair in NHSII and a 33% lower hazard (HR, 0.67; 95% CI, 0.48-0.94) of death from despair in HPFS.

CONCLUSIONS AND RELEVANCE The findings suggest that religious service attendance is associated with a lower risk of death from despair among health care professionals. These results may be important in understanding trends in deaths from despair in the general population.

JAMA Psychiatry. 2020;77(7):737-744. doi:10.1001/jamapsychiatry.2020.0175
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Editorial page 670
Author Audio Interview
Supplemental content

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Recovery: Holistic Approach

- Biological
- Psychological
- Social
- Spiritual

Resilience What is it?

Resilio– to bounce back to rebound

Grit– Perserverance and Passion

Wabi Sabi– made more beautiful by imperfection

Harzbrand,Groopman, NEJM 2020
Living Wabi Sabi, T. Gold, 2010

Resilient People:

- Intrinsic Factors:
  - Positive Attitudes. (where's the Pony joke)
  - Optimism
  - Ability to Emotionally Self Regulate
  - See problems and failures as learning experiences
- Extrinsic factors may play a part:
  - Social and environmental supports

(McKinley et al, 2019)

Brief Resilience Scale (BRS)

Please respond to each item by marking one box per row		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
BRS 1	I tend to bounce back quickly after hard times	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
BRS 2	I have a hard time making it through stressful events.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
BRS 3	It does not take me long to recover from a stressful event.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
BRS 4	It is hard for me to snap back when something bad happens.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
BRS 5	I usually come through difficult times with little trouble.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
BRS 6	I tend to take a long time to get over set-backs in my life.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Scoring: Add the responses varying from 1-5 for all six items giving a range from 6-30. Divide the total sum by the total number of questions answered.

My score: _____ item average / 6

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: assessing the ability to bounce back. *International journal of behavioral medicine*, *15*(3), 194-200.

Although Resilient, Many Mental Healthcare Providers Develop

- Burnout
- Depression
- Moral injury
- Substance abuse

- Pandemic– adding to increasing stress/acute and Post-Traumatic Stress Disorder symptoms

Physicians Experience Highest Suicide Rate of Any Profession

- Deepika Tanwar, MD presented study findings at American Psychiatric Association (APA) May 2018 Annual Meeting:

- Male physicians at 40% higher suicide risk than US males
- Female physicians at 130% higher suicide risk than US females

- 2018 Estimated Suicide rates:
  - *Physicians = **28-40/100,000** (1per day)
  - *Veterans = 30/100, 000 (20 per day)

(* 22 million veterans/323 million US population = 7%
<1 million physicians/323 million US population = 0.3%)

In an Emergency Take Care of Yourself

Aragaki, 2019

Burnout is toxic and Costly

- Burnout is an ICD9 code: QD85 “resulting from chronic workplace stress”
- Burnout causes lack of empathy/cynicism
- Impaired job performance
- Impaired relations with family and friends at the Electronic Health Record invades the home

Harzbrand,Groopman,
NEJM 2020

Physician Burnout = Public Health Crisis

- Unintentional accidents = 3rd leading cause of death
- Costs of burnout: 4.6 billion dollars
- 2016 Johns Hopkins study reported 250,000 deaths due to medical errors. (Other studies estimate closer to 440,000)

Herzberg and Groopman 2020
Aragaki, 2019

Burnout is Loss of Motivation

Motivation –
Intrinsic motivation
Extrinsic motivation
(Positive and Negative)

Pardoxically: Monetary Awards UNDERMINE Intrinsic Motivation
however:

Best extrinsic motivators: Annual Pay Raise, Annual Bonus

Bringing Money into the FORE with Each Patient
Interaction **(RVUS)**
Decreases Intrinsic motivation

Harzbrand,Groopman, NEJM 2020

Burnout in Clinicians/MDs Related to lack of control

They Don’t control their own Schedule

They don’t control the language they can use even in their charting

Every hour of patient time is met with two hours of computer time

Hartzbrand,Groopman NEJM 2020

Burnout Symptoms + Energy Accounts

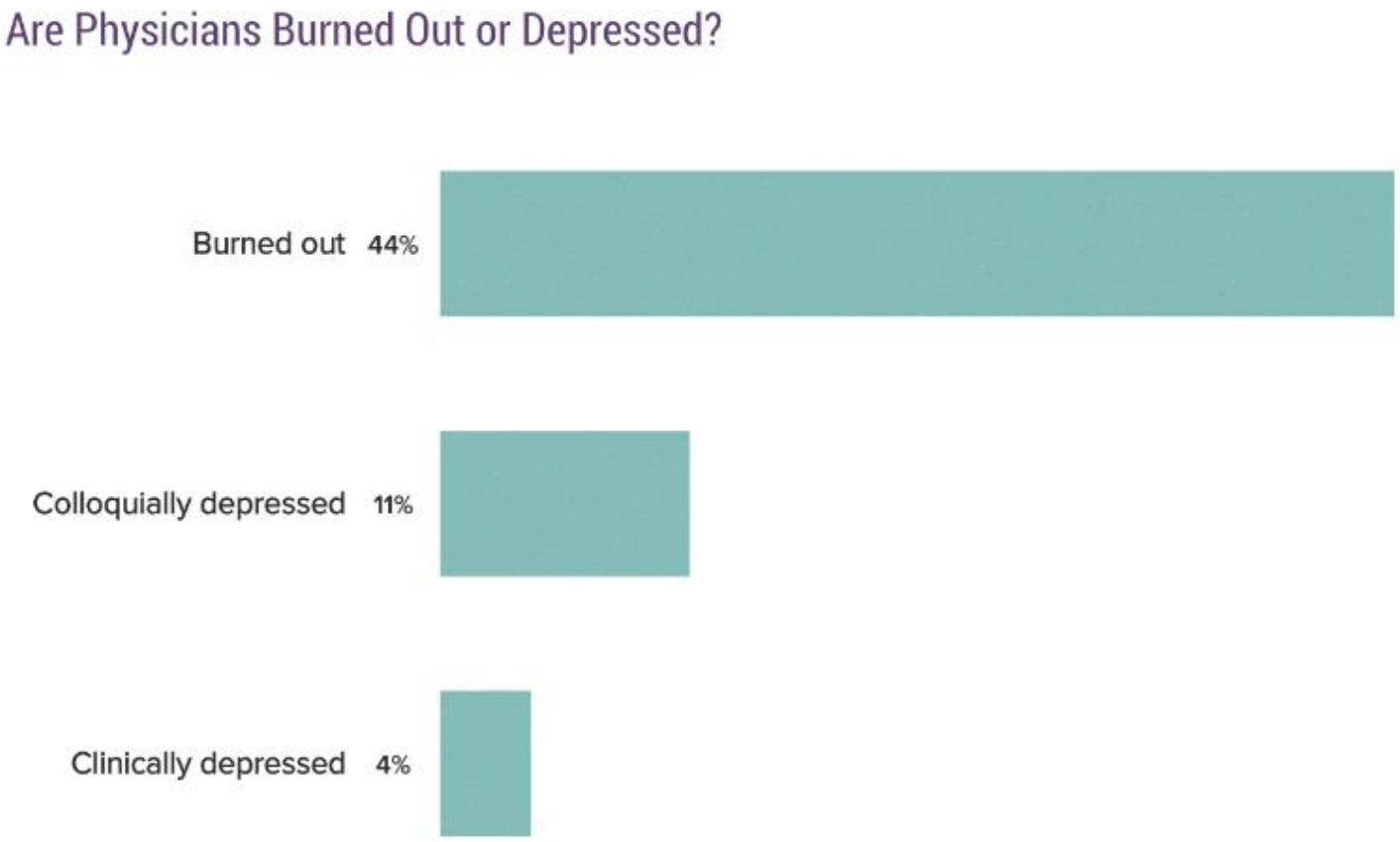
EXHAUSTION ⟷ PHYSICAL ENERGY

DEPERSONALIZATION ⟷ EMOTIONAL ENERGY

LACK OF EFFICACY ⟷ SPIRITUAL ENERGY

Aragaki, 2019

Medscape National Survey Results



Aragaki,2019

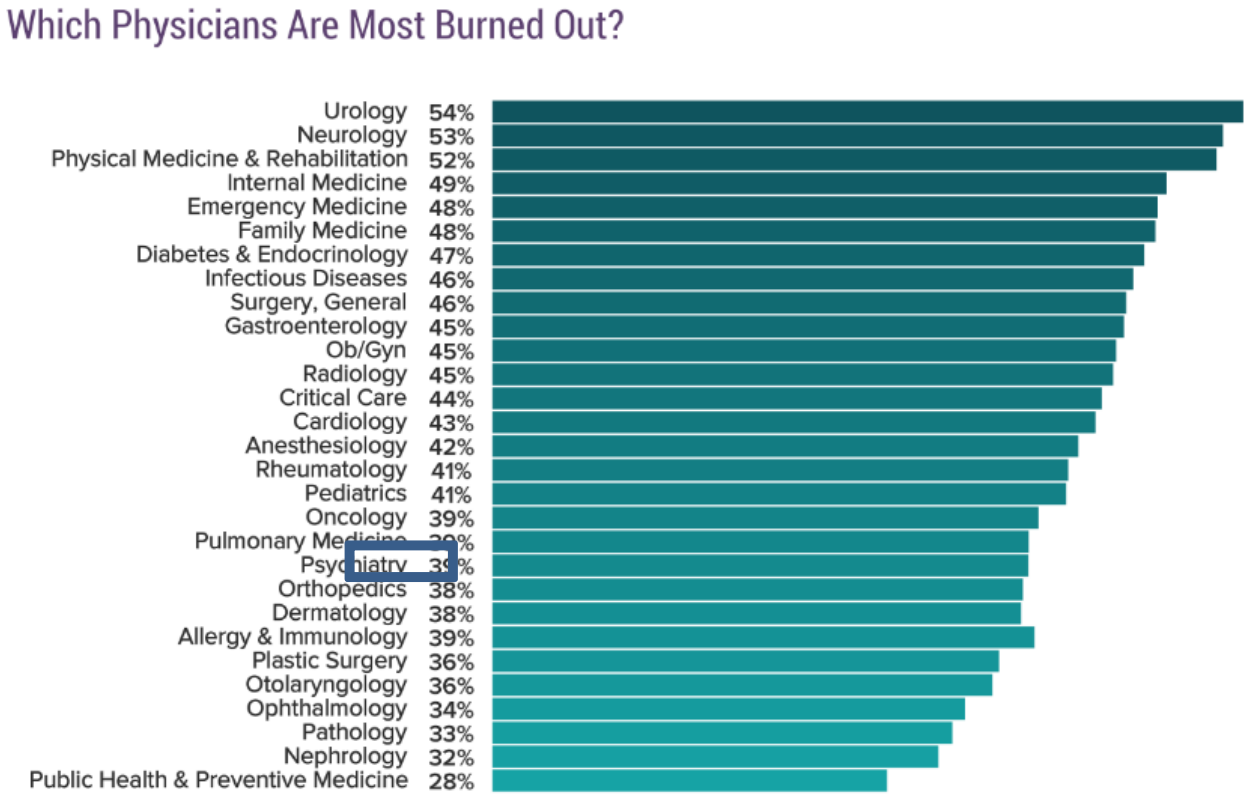
Burnout in Therapists:

1) American Psychological Association Report 2018:
Estimates of 21- 61 Percent of Mental Health Providers are Burned out

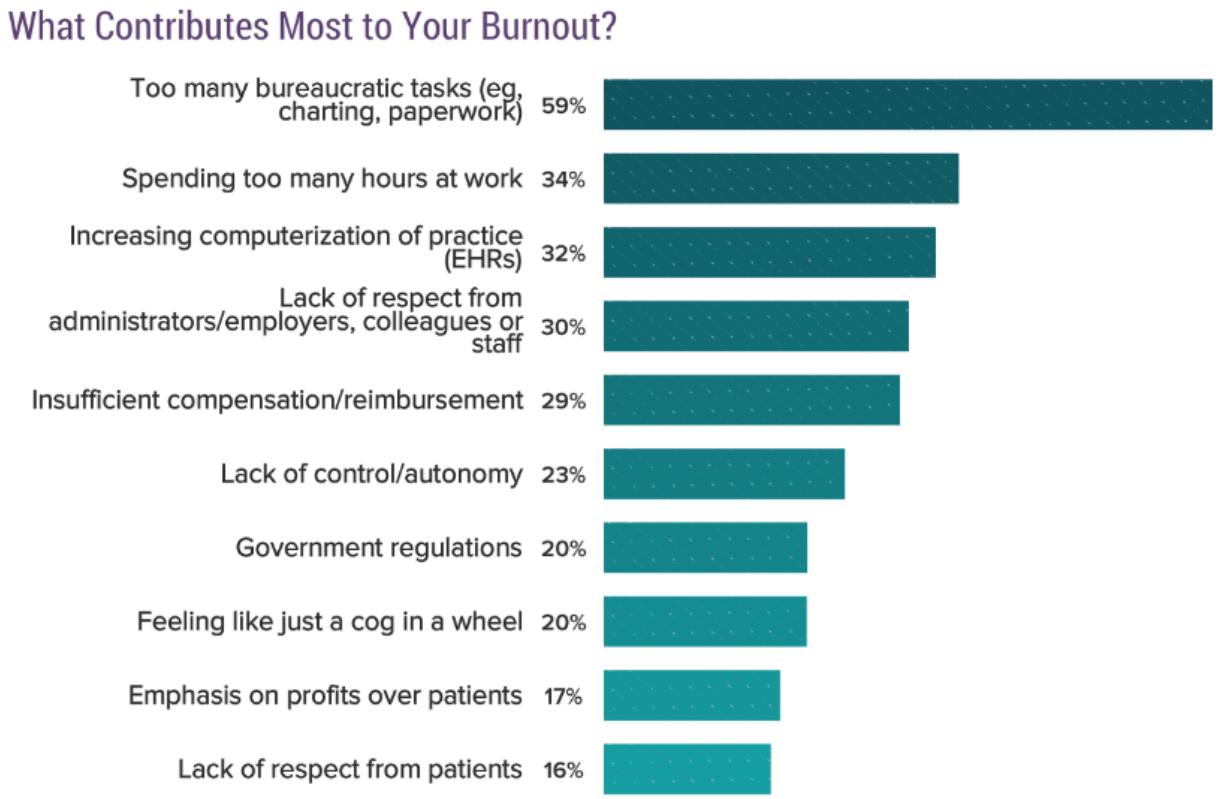
2) Review Paper in 2018 Examined the results of studies of 9000 therapists
And found that 50 percent suffered form burnout

Simionato, Simpson, 2018
Weinreich, 2015

Medscape National Survey Results 2019



Medscape National Survey Results 2019



Aragaki, 2019

THREE Pillars THAT Prevent Burnout

Autonomy

Competence

Relatedness

Hartzbrand,Groopman NEJM 2020

Restore Autonomy, use Appropriate measures of Competence

- The System needs to Restore Autonomy to the doctor/provider
- Flexible scheduling that treats clinicians and patients as individuals
- Flexible scheduling allowing clinicians to optimize their relatedness to their patients as opposed to the Electronic Health Record
- Purge System of MEANINGLESS metrics
- Relatedness should be authentic
- The System needs to adopt to clinican and patients' needs

Hartzbrand, Groopman NEJM 2020

Keys for Energy Saving:

1)End workday at the end of pay day

2)Take 1 hour lunch/rest daily

3)Take every earned vacation day every year

4)Take At least one day off per month to recharge!

5)Take complete electronic Sabbath 1 day per week

6)Do Not look at EHR at end of work -day or work e-mail

7)Lean into supportive relationships

8)Work on your own Recovery Plan!!!

Recovery Planning: Suicide Prevention Planning

My Personal Recovery Plan

Instructions: Please fill this out (with or without assistance) and then return and discuss it with your primary mental health team/provider

STEP 1: Satisfaction with Areas of My Life. Please tell us how satisfied you are with the areas of your life. For each area, rate your level of satisfaction #1-5 (**1 = not satisfied; 3 = moderately satisfied; 5 = very satisfied**) and tell us in a few words why you feel that way

Life area	#1-5	My level of satisfaction is ___ because _____.
Physical needs (food, clothing, shelter)		
Meaningful activities (work, school, volunteer) in the community		
Social relationships (friends, family, intimacy, etc)		
Holistic/Spirituality/Wellness (Mind, Body, Spirit)		
Recreation, Leisure, Hobbies, Creative Expressions (music, art, dance, writing, etc)		
Other:		

STEP 2: What is my overall vision of recovery? If my life could be anything I wanted it to be, what would it look like? What brings meaning to my life? What is meaningful to me?

_____
_____
_____
_____

STEP 3: What goals will I set to reach my vision of recovery? I will work on the following goal(s) to improve satisfaction in one or more of the life areas (from **STEP 1**):

_____
_____
_____
_____

STEP 4: What strengths do I have that will help me achieve my recovery goals? What are the things that I am good at doing? What are some past successes that will help me to achieve my recovery goals? What relationships or associations will help me to achieve my recovery goals?

_____
_____
_____
_____
_____

T. Fletcher, LCSW, Local Recovery Coordinator, 5/8/09

Page 1

Walsh's Recommended Therapeutic Lifestyle Changes (TLCs)

- Exercise
- Nutrition and diet
- Time in nature
- Recreation
- Relaxation
- Stress management
- Religious and spiritual involvement
- Community involvement- volunteerism

Walsh, 2011

TLC Diary

My THERAPEUTIC LIFESTYLE PRACTICES DIARY
THE 8 WAYS TO PRACTICE TLC'S

Name: _____

Date: _____

My goal is to make little changes for each lifestyle element to improve the quality of my life.

	Specific Goals	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Exercise								
Nutrition and Diet								
Time in Nature								
Relationships								
Recreation								
Relaxation / Stress Management								
Religious/Spiritual Involvement								
Service and Helping Others								

(Tessier, 2017; Walsh 2011)

SMART Goals For TLCs!

Specific

Measurable

Attainable

Realistic

Time-bound

(Doran, 1981)

TLC Materials Developed:

- TLC Diaries
- TLC Workbooks
- TLC Training manual
- TLC Single worksheets

MILITARY MEDICINE, 182, X:X, 2017

Therapeutic Lifestyle Changes: Impact on Weight, Quality of Life, and Psychiatric Symptoms in Veterans With Mental Illness

Jillian M. Tessier, BA; Zachary D. Erickson, BA†; Hilary B. Meyer, BA‡; Matthew R. Baker, BA§; Hollie A. Gelberg, PhD, RD†; Irina Y. Arnold, MD†; Crystal Kwan, MPH, RD†; Valery Chamberlin, MD†‖; Jennifer A. Rosen, PharmD, BPCC¶**††; Chandresh Shah, MD†; Gerhard Hellemann, PhD‖; Melissa M. Lewis, PhD†; Charles Nguyen, MD‡‡; Neena Sachinvala, MD†; Binyamin Amrami, MD†‖§§; Joseph M. Pierre, MD†‖; Donna Ames, MD†‖*

ABSTRACT Introduction: Veterans with mental illness tend to have shorter life spans and suboptimal physical health because of a variety of factors. These factors include poor nutrition, being overweight, and smoking cigarettes. Nonphysical contributors that may affect quality of life are the stigma associated with mental illness, social difficulties, and spiritual crises. Current mental health treatment focuses primarily on the delivery of medication and evidence-based psychotherapies, which may not affect all the above areas of a Veteran's life as they focus primarily on improving psychological symptoms. Clinicians may find greater success using integrative, comprehensive, multifaceted programs to treat these problems spanning the biological, psychological, social, and spiritual domains. These pilot studies test an adjunctive, holistic, behavioral approach to treat mental illness. This pilot work explores the hypotheses that engagement in a greater number of therapeutic lifestyle changes (TLCs) leads to improvement in quality of life, reduction of psychiatric symptoms, and weight loss. Materials and Methods: Institutional Review Boards for human subjects at the Veterans Affairs (VA) Greater Los Angeles and Long Beach Healthcare Systems approved pilot study activities at their sites. Pilot Study 1 was a prospective survey study of Veterans with mental illness, who gained weight on an atypical antipsychotic medication regimen, participating in a weight management study. At each session of the 1-year study, researchers asked a convenience sample of 55 Veterans in the treatment arm whether they engaged in each of the eight TLCs: exercise, nutrition/diet, stress management and relaxation, time in nature, relationships, service to others, religious or spiritual involvement, and recreation. Pilot Study 2 applied the TLC behavioral intervention and examined 19 Veterans with mental illness, who attended four classes about TLCs, received individual counseling over 9 weeks, and maintained journals to track TLC practice. Besides weekly journals, researchers also collected prospective data on quality of life, psychiatric symptoms, vitals, and anthropometric measurements. In both studies, investigators tested for main effects of the total number of TLCs practiced and study week using mixed-effects linear models with independent intercepts by participant. Results: In Study 1, engagement in more TLC behaviors was significantly associated with higher ratings of quality of life, as well as greater weight loss for each additional type of TLC practiced. In Study 2, TLC practice increased significantly over 9 weeks, and was significantly associated with improvements in quality of life and diastolic blood pressure. Conclusion: Counseling Veterans to practice TLCs provides a holistic adjunct to current treatments for mental illness. TLCs may confer multiple benefits upon Veterans with mental illness, enhancing quality of life and well-being along with weight management efforts. As these were pilot studies, the samples sizes were relatively small and a control group was lacking. Our findings may have broader implications supporting a holistic approach in both primary and mental health care settings. Future research will expand this work to address its weaknesses and examine the cost differential between this holistic approach and traditional mental health treatment.

Lifestyle Changes Program

Participant Notebook

Materials Developed by Hilary Meyer, Jillian Tessier, Irina Arnold, Zach Erickson, Hollie Gelberg, Crystal Kwan & Donna Ames, MD

Portions Adapted from Diabetes Prevention Program
Supported by grant funding from the VA Merit Review Program, Department of Rehabilitation R&D
Version 3, 11/16/14

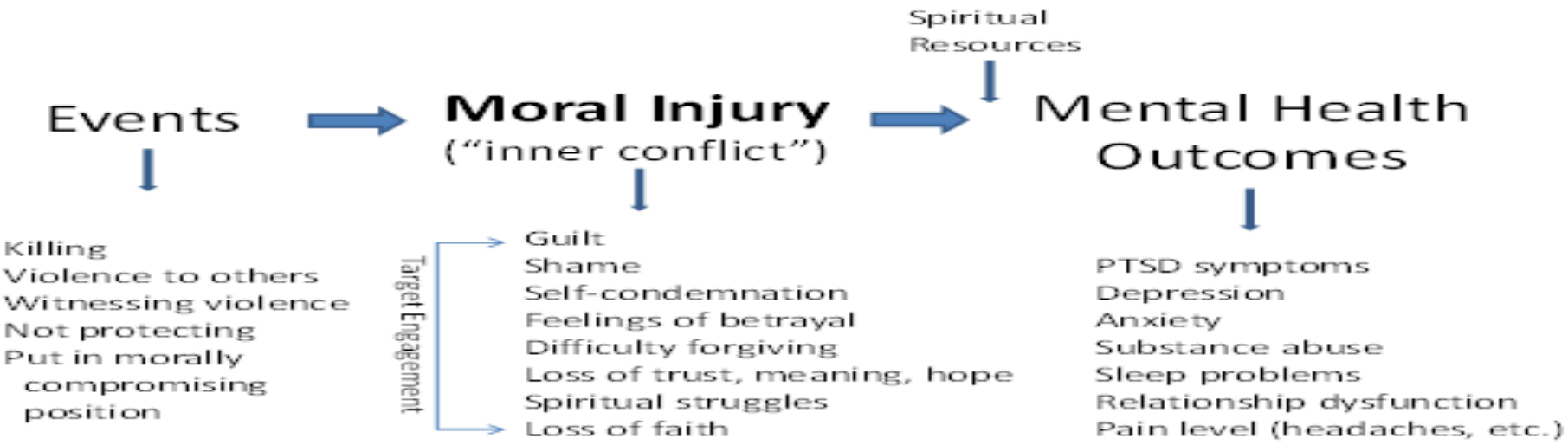
VA GREATER LOS ANGELES HEALTHCARE SYSTEM
A Division of VA Desert Pacific Healthcare Network

VA HEALTH CARE Defining EXCELLENCE in the 21st Century

All symbols included above are "Dancing" by Matt Brooks, from the thenounproject.com

Moral Injury Model

Moral injury can impact Veterans and Civilians



Koenig, 2018, Kopacz, 2019

Definitions of Moral Injury

- "Perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations." (Litz et al., 2009)
- "a betrayal of what's right, by someone who holds legitimate authority, in a high-stakes situation" (Shay, 2014, p 183)
- "a deep sense of transgression including feelings of shame, grief, meaninglessness, and remorse from having violated core moral beliefs" (Brock & Lettini, 2012, p xiv)

Moral Injury and PTSD

- Moral injury is not PTSD. Persons with PTSD may also suffer from moral injury. But persons with moral injury may not necessarily have all the symptoms of PTSD.
- The presence of moral injury may complicate the recovery of persons with PTSD only receiving treatment that is focused on PTSD, and resolving MI may also improve PTSD or make it more amenable to standard treatments.
- PTSD associated with: (1)Traumatic Event (2)Intrusions (3)Avoidance (4)Negative Cognitions (5)Increased Arousal
- Moral Injury associated with: Shame, guilt, betrayal, moral concerns, spiritual distress

Items: MISS-M-SF

1. I feel betrayed by leaders who I once trusted.
2. I feel guilt over failing to save the life of someone in war.
3. I feel ashamed about what I did or did not do during this time.
4. I am troubled by having acted in ways that violated my own morals or values.
5. Most people are trustworthy.
6. I have a good sense of what makes my life meaningful.
7. I have forgiven myself for what happened to me or others during combat.
8. All in all, I am inclined to feel that I am a failure.
9. I wondered what I did for God to punish me.
10. Compared to when you first went into the military has your religious faith since then... Weakened or Strengthened

Moral Injury Symptoms and Suicide Risk

- Growing evidence of link between moral injury and increased suicide risk
- Published study of 570 Veterans and Active Duty Military
  - Measured moral injury, suicide risk index based on 10 known suicide risk factors
  - Measured religiosity and moderating effect of religion
- Moral injury strongly correlated with suicide risk (r=0.54)
  - Self-condemnation had the highest subscale correlation with MI
  - Religiosity did not mediate relationship between moral injury and suicide risk

Ames, 2018

Moral Injury and Spirituality/Religiosity

- Religiosity/Spirituality (R/S) in Veterans has been inversely related to PTSD symptoms (Currier et al., 2014).
- And positively correlated with "Post Traumatic Growth" (Tsai et al., 2015)
- In our study 90% of Veterans with PTSD symptoms reported Moral Injury symptoms as well.
- Overall, religiosity was inversely related to moral injury in Veterans with Severe PTSD. (religiosity measured by validated measure, BIAC) (Koenig et al., 2018)

Moral Injury and Treatment Preference

- What is the preference of Veterans in terms of treatment modality/provider?
- Some Veterans may prefer Chaplains
- Others may prefer mental health provider
- Stigma associated with mental illness– Veterans may prefer getting help in their faith-based community leader
- Mental health/psychiatry should partner with faith-based communities to help Veterans
- Also, within the VA mental health and chaplains should collaborate
- In one recent publication by this group Youssef et al, 2018, 80% of Veterans were open to a spiritually oriented treatment

Spiritually Integrated Cognitive Processing Therapy

- Spiritually integrated form of CPT that explicitly draws on a client's spiritual/religious resources and that addresses spiritual struggles and moral injuries.
  - Spiritual beliefs, practices, rituals, values, and inspirational passages to challenge and change unhelpful patterns of thinking and behavior
  - Spiritual concepts, such as kindness, compassion, and acceptance
  - Spiritual practices, such as confession, forgiveness, making amends, spiritual surrender, prayer/meditation, and spiritual community
- Targets MI to reduce PTSD symptoms
- 5 religion-specific appendices (Pearce et. al., 2018)

Structured Chaplain Intervention for Treatment of Moral Injury

- This intervention consists of twelve 50-minute individual one-on-one pastoral care sessions with the Veteran

- The intervention is designed specifically for those who indicate that religion is important in their lives. It is to be adapted to the specific religious beliefs of the Veteran. (Koenig et al., 2019)

Contents of Chaplain Intervention Cont.

III. Modules based upon Model of Healing:

Conviction

Lament

Repentance

Confession

Forgiveness

Reconciliation

Atonement

Recovery & Resilience

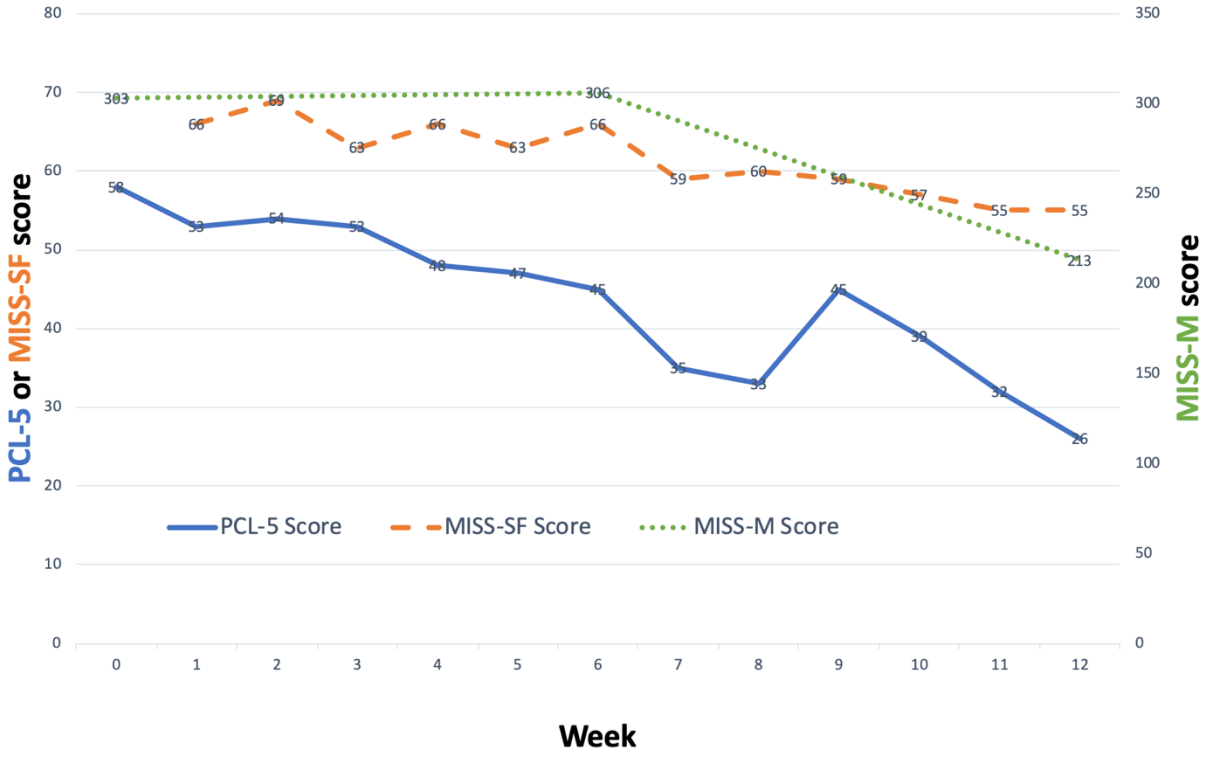
Anger (optional)

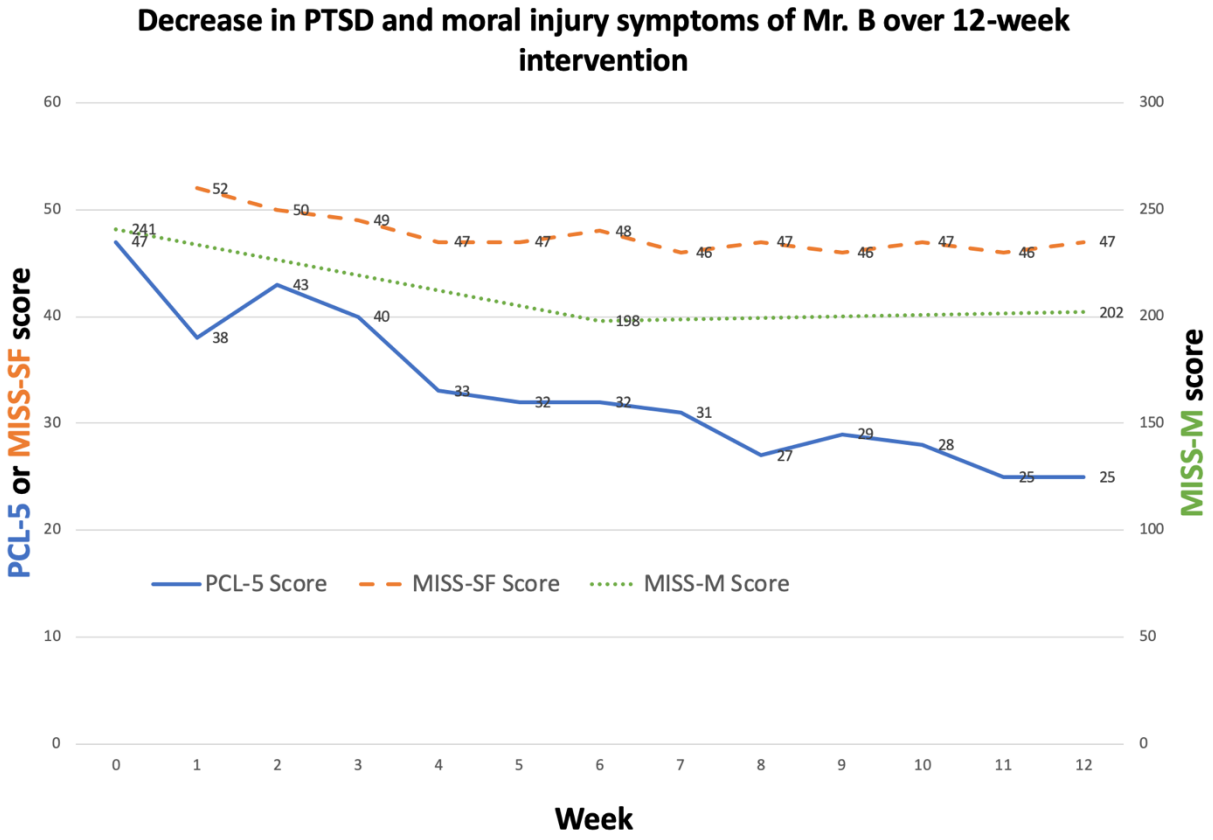
Contents of Chaplain Intervention

II. 10 Moral Injury Dimensions (Content for Sessions)

1. Guilt
2. Shame
3. Betrayal
4. Moral concerns
5. Loss of trust
6. Loss of meaning
7. Self-condemnation
8. Difficulty forgiving
9. Religious struggles
10. Loss of religious faith

Decrease in PTSD and moral injury symptoms of Mr. A over 12-week intervention




Decrease in PTSD and moral injury symptoms of Mr. B over 12-week intervention
PCL-5 or MISS-SF score
MISS-M score
Week
PCL-5 Score
MISS-SF Score
MISS-M Score
60
50
40
30
20
10
0
300
250
200
150
100
50
0
0 1 2 3 4 5 6 7 8 9 10 11 12
47 38 43 40 33 32 32 31 27 29 28 25 25
52 50 49 47 47 48 46 47 46 47 46 47
241 198 202

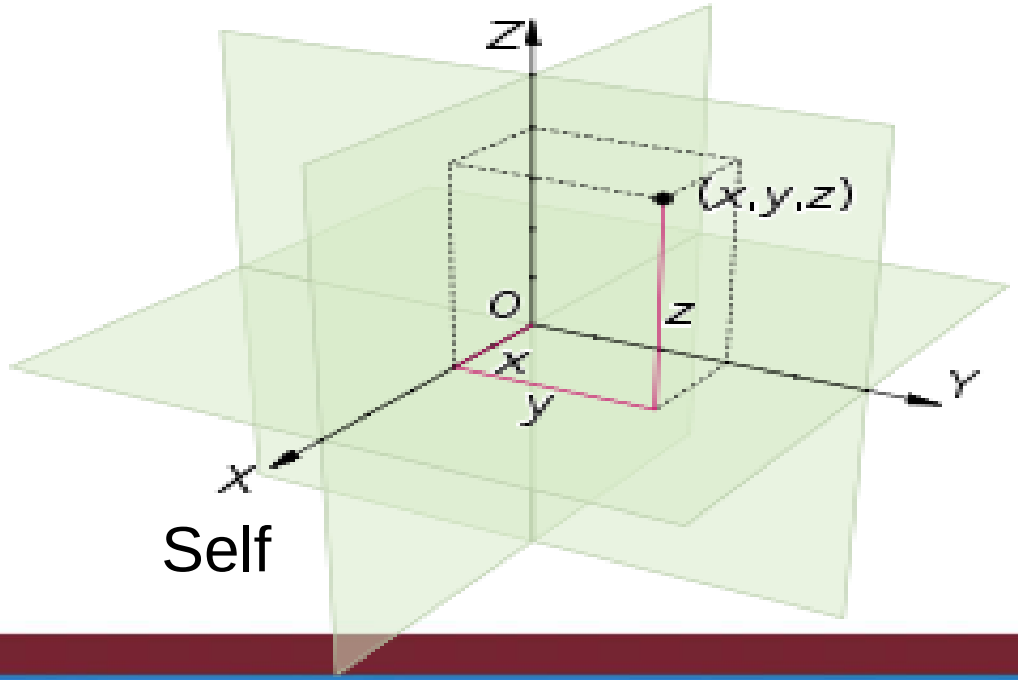
Future research: Moral injury and Relationship Problems/Anger/Forgiveness

- We are spiritual beings
- “We are all struggling with a relationship problem” (Glasser, 1999)
- Is there a problem with a relationship with self? (self-loathing- a part of moral injury)
- Is there a problem in a relationship with others(withdrawal from friends, family, work).
- Is there a problem with a relationship with God or higher power a sense of purpose or meaning? (Spiritual Struggles)
- How do these relationship problems then affect the soul– the mind, the will, the emotions? (Nee, 1968)

SIMPLE AS X Y Z

- On a scale of 1-10 on each axis what is the health of this spiritual being in terms of relationships with self, others and Higher Power?

Higher Power



Others

Self

Wikipedia image

Ratsch, 2019

Themes of Forgiveness – Prodigal Son Luke: 15 11-31

- There is a loving G-d who wants to hold us in his arms no matter how broken we are
- And never gives up on us coming home
- Imagine if we all treated each other with the compassion, mercy, forgiveness, grace and unending love that the prodigal's father, had for him (Boyle, "Tattoos on The Heart," 2010)

Working with Faith Leaders::

Research Study: *Helping Los Angeles Faith-Communities Prevent Veteran Suicide During Periods of Transition Back into Civilian Life*

- Methods: Conduct Focus Groups with 10 faith based leaders
- Learn from focus groups about the challenges and the solutions they have come up with to help Veterans with mental health issues and suicidal ideation
- Collect resources to provide to Faith Communities to help with connecting Veterans with the VHA. (most suicides amongst Veterans are not amongst Veterans connected with VHA).
- Continue a dialogue with Faith Leaders and plan to distribute materials to them to help with addressing PTSD and Moral injury through Spiritually Integrated interventions.

Kopacz, Santiago, Yahalom, Erickson, Tiwari, Sahknao, VanHoof, Koenig, Ames, Et al, in preparation

Summary

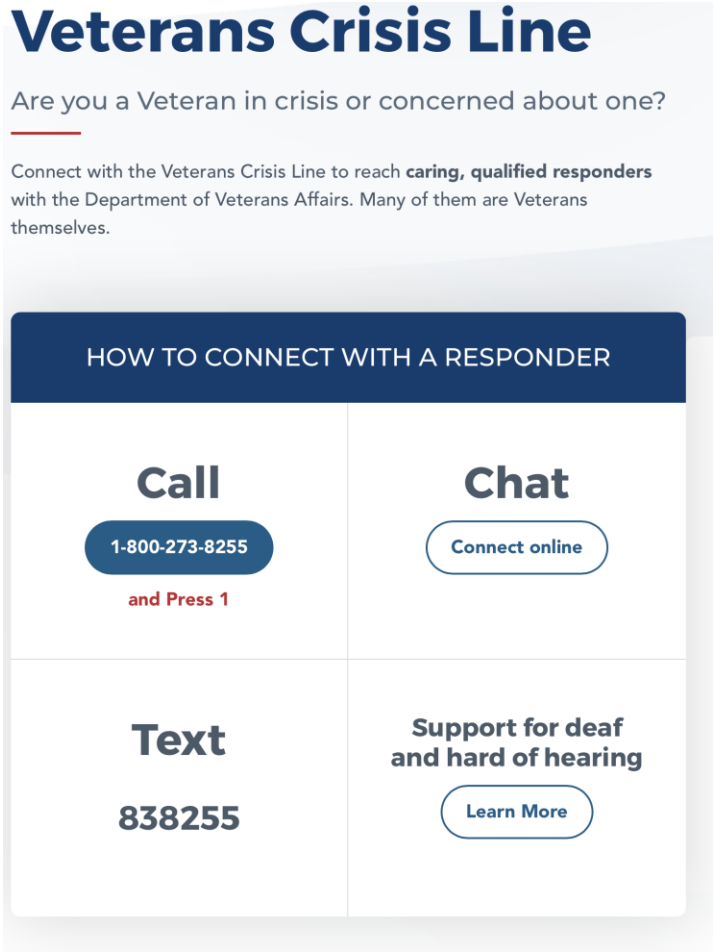
- Mental Health Care and Suicide Prevention should be recovery oriented and include a holistic, bio-psycho-social-spiritual approach.
- Moral injury should be recognized as it may explain why Veterans with PTSD do not fully recover with currently available treatments for PTSD.
- Veterans may prefer and actually benefit from treatments utilizing a spiritually integrated, approaches.
- Spiritually integrated interventions for moral injury and PTSD provide VA mental health providers opportunities to collaborate with chaplains and faith-based communities to optimize care of Veterans.

Summary Continued

A holistic, bio-psycho-social-spiritual Recovery model must also be applied to ourselves to optimize our well being, to support our resilience, and prevent burnout.

We must all engage in therapeutic lifestyle changes and support one another on our own recovery journeys!

1 800 273 8255 press 1



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