BSS Facilitator Education

Chaplain/Mental Health Professional Education for Group Facilitation

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**Introduction**

 As a minister/chaplain/mental health professional you have already been trained and had experience in a variety of interpersonal and counseling skills. In this manual, we will give you a reminder of some interventions you have already been performing and provide examples of other skills that may be helpful in facilitating groups. This manual is meant to give you a baseline to work from and is intended to be supplemented by 16 hours of face-to-face training, a number of books, scholarly articles, and two websites[[1]](#footnote-1). Learning the Art of Helping by Mark E. Young and The Theory and Practice of Group Psychotherapy by Irvin Yalom and Molyn Leszcz were heavily drawn from to make this portion of the manual and are excellent places to explore these topics in greater depth.[[2]](#footnote-2) Two helpful websites are: https://www.ptsd.va.gov/ and the Building Spiritual Strength YouTube channel: https://www.youtube.com/playlist?list=PLnh2PvQFlZsnaxU0sPA-8W24OsHxdgqFo

**Relevant Background[[3]](#footnote-3)**

Studies estimate only 6-11% of all Veterans with posttraumatic stress disorder (PTSD) actually start an Evidence Based Psychotherapy (EBP) for PTSD (Mott et al., 2014; Shiner et al., 2012). Among those who do, 30% - 50% fail to show clinically significant improvements (Schnurr et al., 2007; Kehle-Forbes et al., 2016). This may be due in part to dropout, which ranges from 30% - 38% in randomized trials (Schnurr et al., 2007; Kehle-Forbes et al., 2016; Suris et al., 2013) and 32% - 49% in clinic based studies (Kehle-Forbes et al., 2016; Suris et al., 2013; Tuerk 2011). In a sample of 427 Veterans who were scheduled to begin Prolonged Exposure (PE) or Cognitive Processing Therapy (CPT) in a Veterans Affairs (VA) PTSD Clinic, only 51% completed treatment; 17% dropped out before the first session, and 34% later dropped out (Kehle-Forbes et al., 2014). While there are excellent treatments for PTSD available, many are not reaching veterans who may benefit from them. Spiritually integrated health care approaches that are potentially more socially accepted and accessible to veterans could prove useful in getting meaningful care to those who are currently not accessing conventional services.

Spiritually integrated care is defined as a collaborative therapeutic method that utilizes and incorporates the patient’s spiritual and religious practices and beliefs in the treatment of mental health issues (Saunders, 2010). Studies indicate that while psychologists see the importance in addressing and incorporating spiritual and religious beliefs into treatment, many reported a lack of proficiency (Frazier & Hansen, 2009). This may be due to a lack of education and training during clinical internship or post-graduate training (Saunders, 2010).

Spiritually integrated services may provide more effective options for addressing moral injury for veterans. Although operationalization of the construct is still developing; moral injury involves a number of psychological symptoms (e.g., guilt, shame, anger, etc.) that come about as the result of experiential challenges that violate deeply held moral beliefs or values (Litz et al., 2009*).* Service Members are required to engage in activities that may be considered immoral in different social contexts, and this has been recognized as a potential source of moral injury (Drescher et al., 2011; Litz et al., 2009; Maguen et al., 2011). Moral injury may also be the result of exposure to others’ suffering, involvement in morally ambiguous contexts, or loss of trust in leadership (Currier et al., 2015; Drescher et al., 2011; Litz et al., 2009).

Building Spiritual Strength (BSS; Harris et al., 2011) is a manualized, spiritually integrated group intervention for posttraumatic stress designed to a) engage veterans who do not engage in conventional mental health services, and b) leverage spiritual/religious coping as a tool to address both symptoms of PTSD and moral injury. In a pilot study of BSS, veterans who participated in an 8-week BSS group experienced significant reductions in posttraumatic stress symptoms as compared to veterans in a wait-list control group (Harris et al., 2011). Furthermore, in a subsequent study, significant reductions in moral distress were observed in BSS participants as compared to veterans in a Present Centered Group Therapy (PCGT) control group (Harris, 2015).

BSS is designed to help participants better utilize their already existing spiritual resources to more effectively cope with a trauma (Harris et al., 2011), and was designed based on cross-sectional and longitudinal study of relationships between spirituality and resilience after trauma exposure (Currier, Holland & Drescher, 2015; Harris et al., 2008; Ogden et al., 2011; Harris et al., 2012). Session one involves establishing rapport among the group through sharing military and religious backgrounds, setting spiritual goals, and establishing group rules/guidelines. Sessions two and three include experiential and written prayer or meditation exercises. The goal of these two sessions is to reduce spiritual distress in the client’s relationship with any Higher Power or Universal Force. Session four facilitates the development of a personal theodicy (i.e., explaining the existence of evil). Session five facilitates active versus avoidant spiritual coping. Sessions six and seven facilitate forgiveness and conflict resolution with self, others, and Higher Power or Universe. Finally, session eight addresses termination concerns, self-evaluation of spiritual goals, and planning for continued personal spiritual development (Harris et al., 2011). BSS addresses spiritual concerns and works to resolve the stress those concerns generate, while simultaneously supporting current spiritual functioning and promoting positive adjustment, without imposing theological beliefs inconsistent with clients’ religious identification. Leaders may be mental health providers with a specialized background in spirituality, or clergy with a specialized background in mental health (Harris et al., 2011).

While preliminary studies indicate that BSS is a promising intervention for posttraumatic stress and moral injury, current empirical findings are insufficient to identify mechanisms of action. Current results may be due to common factors, or specific spiritual coping training in the BSS condition. One of the most likely mechanisms of action may be changes in spiritual coping over the course of BSS. Spiritual coping is one of the many ways individuals manage stress, trauma, and other life events. It can be best described as a style of coping that comes out of religious or spiritual traditions, beliefs, rituals, emotions, and relationships (Abu-Raiya & Pargament, 2015). In relevant literature, spiritual coping is typically described in positive or negative terms. Positive spiritual coping can encompass seeking spiritual support, finding forgiveness in religion, and using religion to positively reframe life experiences. Negative spiritual coping (also identified in the literature as religious or spiritual struggles and strains; Exline et al., 2000; Exline et al., 2014) can include an unstable relationship with a Higher Power, experiencing the world as a threatening place, and wrestling to find meaning through religion (Pargament et al., 1998). Pargament et al. (2005) defines three types of religious struggles that can be used to better understand spiritual coping: divine, intrapersonal, and interpersonal. These categories are helpful in defining an individual’s spiritual struggle in a broader context. Interpersonal spiritual struggle refers to challenges around communities of faith, families, and social circles. Intrapersonal spiritual struggle can encompass uncertainty around theology, and incongruence between religious traditions and actions. Finally, divine spiritual struggle refers to challenges one faces in relating to a higher power or the divine.

In a recently published study, spiritual distress at the start of inpatient trauma treatment predicted PTSD symptom severity at discharge, but symptom severity did not predict subsequent spiritual distress. These findings suggest that spiritual distress has a potential etiological role in the severity and course of PTSD (Currier, Holland, & Drescher, 2015). Empirical study shows that seeking spiritual support is positively linked to posttraumatic growth and conversely, religious strain is correlated with posttraumatic stress symptoms (Harris et al., 2008). Harris et al. (2008) also demonstrated that posttraumatic growth was positively correlated with positive religious coping. The purpose of this study is to examine the changes in religious and spiritual coping associated with BSS participation as a foundation for developing hypotheses about mechanisms of action relevant in BSS. While in general, positive spiritual and religious coping are associated with better mental health outcomes (Ano & Vasconcelles, 2005), previous studies specific to trauma have indicated that positive spiritual and religious coping is associated with posttraumatic growth, but not with posttraumatic stress (Harris et al., 2008).

**Working in a pluralistic environment**

Perform or provide is an often-repeated mantra in military chaplaincy and can be helpful in understanding the role of a group facilitator in Building Spiritual Strength. In this intervention, we would never ask a facilitator or participant to act in way that is contrary to their spirituality or value system. The purpose of the intervention is not to convert participants to a faith group, but to reconnect them with a spirituality or belief system that they find helpful. It is not uncommon for participants to reconnect with a faith tradition or spirituality, but the process is driven entirely by the participant. As facilitators, we need to walk the careful line of questioning problematic areas in a participants belief system, while not leading them to a specific faith/spirituality to answer it.

Practically, there are a number of things we can do as facilitators to ensure all members of the group feel welcome. In the first and second session of the group, facilitators need to get a good grasp of the faith/spirituality/value perspective of all participants. This allows the facilitator to address each group member appropriately with language that is consistent with her or his belief system (if it is not clear, don’t hesitate to ask!). It is not uncommon to ask one group member how their prayer log is going and immediately ask the next member how things went in their meditation journal! Addressing the group in an inclusive manner is just as important as addressing individuals in that way. If the entire group comes from a similar Christian background, it is usually acceptable to speak about a higher power in language that is consistent with those traditions. In the same way, if there are participants from Jewish, Muslim, Buddhist, Atheist, Agnostic, Hindu, Native American or other spiritual backgrounds, it is important to address the group with welcoming language (again, don’t hesitate to ask the group to come up with this). Finally, it is not uncommon to work with a participant whose faith tradition places a high value on proselytizing/evangelism. In those cases, we strongly encourage participants to engage in that practice *outside* of the group, as the group is not an appropriate place for proselytizing/evangelism.

**What is an EBP?**

Evidenced based psychotherapies (EBPs) are manualized interventions that have been put through a series of tests to validate their efficacy. Currently the VA recognizes two protocols for PTSD; Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE). Both protocols have gone through rigorous testing to confirm their efficacy in symptom reduction of PTSD. BSS is currently going through the process of becoming evidence based. Two studies have been completed with promising results. The first, a pilot study, showed BSS significantly reducing symptoms of PTSD compared to a wait list control group. The second, compared BSS with PCGT. Preliminary results show BSS being as effective as PCGT in reducing symptoms of PTSD. BSS was significantly more effective than PCGT in reducing spiritual distress. The purpose of certifying protocols as EBPs are to ensure people benefit from the interventions and that no harm is caused.

**Skills to remember**

Unconditional positive regard is one of the best assets available to a group facilitator. Being welcoming and extending welcome to participants is key to setting up an environment where change can happen. This ranges from the words facilitators use, to their tone of voice, or the body language they offer. Sometimes this can be challenging because during groups we will meet people that rub us the wrong way. Even in those cases we need to do our best to extend welcome and treat those individuals as we would treat any other participant (Young, 2012).

Reflective listening is sometimes so obvious that it can be painful to practice, but it has a significantly positive impact on the therapeutic process. It is simply the process of repeating back to an individual what they have just said. It is both a means of showing participants that the facilitator is listening, but also a way to hear their own words from another individual (Young, 2012). If a participant were to say “I had a rough week,” reflective listening could look like “I heard you say you had a rough week” or “It sounds like you had a rough week.”

Open ended questions are another key part of group facilitation. Yes/no questions will often not foster a meaningful response or group engagement (Young, 2012). There are many ways to do this. Some examples could include: “tell me more about that”, “what does that mean to you?” or “what’s going through your mind right now?” The options are almost limitless, but by keeping questions open, more space is made for individuals to come forward in the group.

Joining takes place at multiple levels in a therapeutic relationship. Initially it is the process of creating a relationship and rapport with a client or patient. This process can be like meeting a new parishioner and helping them to feel welcome in a new environment. It can take place through small talk around common interests, verbal and non-verbal affirmation when speaking to an individual (nodding, open body posture, etc). Often, it is best to allow participants to share more of their story, personal disclosure can be helpful at times, but should only be used in cases where it will benefit participants (Young, 2012).

 Another place joining can be important is immediately after a client shares something significant in a group setting. One way to bring the group around them is asking if anyone else has had a similar experience or feelings. Group members can then form a sense of comradery with one another. Though this can be considered joining, it is also a form of normalizing (Young, 2012). A common occurrence for individuals that have experienced trauma is a sense of isolation or the belief that no one else has had feelings like what she or he is having. Inviting others to share similar experiences or feelings is way to show the client that while their experience is painful, they are not alone in it, nor are they the only person have had such feelings.

 The phrase “finding the silver lining” has been popular recently when an individual is having a negative experience. The phrase points to a technique that is called reframing. When an individual brings forward a complaint, a helping professional can reframe the complaint by restructuring it as a strength. It can help bring clients out of a rigid either/or mentality and allow them to view a situation from a different perspective (Young, 2012). One example of this could be a client sharing that “nobody cares about me.” A facilitator may then say “I hear you saying that you value having meaningful, supportive relationships.” Another way to approach this could be to look for the exception, “No one has ever cared about you?” Likely the individual will be able to name a handful of people or the facilitator could even point to people in the room that have expressed care and concern.

 Paradoxical interventions can be used when working with a client that has shown a tendency to react or act against helping professionals or other authority figures. In many ways, they can be counterintuitive, but have been shown to be very effective when working with individuals that have shown oppositional traits. This could look like, “I want everyone in the group to try this, but John, this might not work for you so don’t give it too much effort.” Oppositional behavior can show up frequently in groups, and in Building Spiritual Strength, it can often come from an individual experiencing an externalizing moral injury.

**Appropriate and inappropriate guilt**

In many religious traditions forgiveness is a significant theme that can be easy to move toward as a minister. In this intervention, there are a couple nuances to be aware of when working with clients around forgiveness. Trauma is nearly always an out of control experience for the individual that has lived through it. In our research, we commonly see people try to retroactively gain control of the trauma by blaming themselves for all or part of what happened (inappropriate guilt). When an individual’s guilt is coming from an attempt to retroactively gain control of trauma, trying to move them towards repentance can cause additional harm. One example of this came forward in working with a Vietnam Veteran. The Veteran blamed himself for his platoon getting ambushed while he was away from them receiving medical care for a different combat injury he sustained. In his reasoning, if he had avoided getting injured, he would have been able to save his platoon or prevent the ambush. Listening as a third party, it is clear this Veteran is assuming a far greater ability to control a combat environment than any individual is likely to have.

 It is important to make this distinction to group participants for their own reflective practice and to pay close attention as a facilitator. There will be many opportunities to work with more classical forgiveness models, but always assess the situation to see if moving towards inappropriate guilt will be more helpful.

**Assessing suicidal ideation (and other mandatory reporting)**

As a minister/chaplain/mental health professional you may already be familiar with laws around mandatory reporting in your state of residence, but below will be a small refresher on mandatory reporting laws in the state of Minnesota (please check with a local authority if in another state). The big issues around mandatory reporting in Minnesota include; threat to harm self, threat to harm another, elder or child abuse, and a pregnant woman abusing substances and refusing treatment. In all cases, it is best to check with a supervisor if you are unsure and do so right away (some reports need to be made within 24 hours). With self or other harm, it is most important to assess intent, plan, and means. Does the person intend to commit the harmful act? Do they have a plan to carry out the act? Do they have the means of carrying out the act?

 Now that we have reviewed the mandatory reporting laws for Minnesota, it is also important that we go over the process of assessing suicidal ideation. There are several things that could indicate a person is thinking of self-harm. These include, but are not limited to the following:

* “Nobody will miss me when I’m gone.”
* “I just don’t think life is worth living anymore.”
* “I wish the pain would just go away.”
* “I have been feeling hopeless lately.”

When a client is presenting in an affective or verbal manner like the above, this can be a good cue to investigate the likelihood of self-harm. Questions to ask could come from the Suicidality Tracking Scale. The goal of your inquiry is to determine whether an individual is safe. A report/intervention should be made if thoughts of suicide are present, the individual has a plan, and the means/intent to carry out that plan. If you are unsure, always refer to a supervisor or other mental health professional for a second evaluation/opinion.

**Group Facilitation**

 One question is important to ask when recruiting patients/participants for a BSS group; is this individual appropriate for group? Answering that question can sometimes be difficult. At the most basic level, we as facilitators need to be reasonably certain that the individual will not cause harm to themselves or others while in a group intervention. Active substance abuse or dependence also raises questions around a potential participants fit for a group trauma/moral injury intervention. If you have not worked significantly with groups in the past, it will be very important to consult with professionals that have experience in group facilitation.

What is presented below comes from Irvin Yalom’s The Theory and Practice of Group Psychotherapy. This book is part of the required reading to prepare to facilitate BSS. In this section, we will be summarizing (and in some cases, drawing verbatim) some of the most important aspects of Yalom’s work (especially problem behaviors and how to work with them).

**Benefits of Group Work and the Role of the Facilitator (Chapters One and Five)**

Yalom outlines many of the benefits of group work including installation of hope, universality, imparting information, and reparative relationships in chapter one of his book. In short, people need to believe change is possible, that they are not alone or completely unique in their suffering, gain a basic understanding of what they are experiencing, and engage in healing relationships (Yalom and Leszcz, 2005). Since chapter one is quite brief, I am not going to repeat it here and refer the reader directly to it.

Groups develop implicit and explicit norms of behavior and interaction. The facilitator plays a large role in shaping and guiding this process (Yalom and Leszcz, 2005). As a facilitator, it will be very important to engage the group in deliberate and authentic ways that promote safety and connection. This does not mean facilitators need to act as if they are walking on eggshells, only that they need to be aware of the influence they hold. Most often this influence can be used in positive ways to promote growth in the group. This modeling could be of non-judgmental acceptance, interpersonal honesty, appropriate self-disclosure, curiosity, or spontaneity (Yalom and Leszcz, 2005). When a facilitator notices a problematic pattern showing up in the group, it is important to address the problem tactfully sooner, then later, before it becomes an ingrained group rule. This paragraph has only been a brief overview of a facilitators role in setting group rules and norms, the reader is encouraged to review chapter five in more detail.

**Problem Behaviors**

 Yalom outlines what he describes as “problem group members” in chapter 13 of his book. In this section, we will briefly describe what to look out for. “The monopolist” is an individually that fills more than their share of space in the group’s dialogue. This could come from telling long stories with little relevance to the group or moving quickly to fill silent spaces before other group members speak. More often than not the excessive speech comes from anxiety, but if left unchecked, it will have a negative impact on the group’s interaction/relationships (Yalom and Leszcz, 2005). In many cases it is helpful to wait a short period of time (a session or two) and see if other group members engage the monopolist around his/her pattern of interacting with the group. At the same time, handling a monopolistic member can sometimes be a challenging task for a group that has recently formed. As a facilitator, it will be important for you to frame the way you address the issue from a couple points of view. You must speak to both the monopolizer’s behavior and the group dynamic that allowed the group to be monopolized. This brings the issues forward in a manner that does not “blame” the monopolizer, but frames their behavior in the context of the group (Yalom and Leszcz, 2005). An example Yalom put’s forward is below:

*“Walt, who had been in the group for seven weeks, launched into a familiar, miliar, lengthy tribute to the remarkable improvement he had undergone. He described in exquisite detail how his chief problem had been that he had not understood the damaging effects his behavior had on others, and how now, having achieved such understanding, he was ready to leave the hospital. The therapist observed that some of the members were restless. One softly pounded his fist into his palm, while others slumped back in a posture of indifference and resignation. He stopped the monopolist by asking the group members how many times they had heard Walt relate this account. All agreed they had heard it at every meeting-in fact, they had heard Walt speak this way in the very first meeting. Furthermore, they had never heard him talk about anything else and knew him only as a story. The members discussed their irritation with Walt, their reluctance to attack him for fear of seriously injuring him, of losing control of themselves, or of painful retaliation. Some spoke of their hopelessness about ever reaching Walt, and of the fact that he related to them only as stick figures without flesh or depth. Still others spoke of their terror of speaking and revealing themselves in the group; therefore, they welcomed Walt's monopolization. A few members expressed pressed their total lack of interest or faith in therapy and therefore failed to intercept Walt because of apathy. Thus the process was overdetermined: A host of interlocking factors resulted in a dynamic equilibrium called monopolization. By halting the runaway process, uncovering and working through the underlying factors, the therapist obtained maximum therapeutic benefit from a potentially crippling group phenomenon. Each member moved closer to group involvement. Walt was no longer permitted or encouraged to participate in a fashion that could not possibly be helpful to him or the group.”*

 “The silent member” falls on the opposite end of the spectrum of problem behaviors, but is still problematic to group process and relationships. A group member may be silent for many different reasons, but Yalom notes that “silence is never silent.” What he means is that silence is a behavior that has an effect on a group (Yalom and Leszcz, 2005). Silence can come from many different places ranging from shame/guilt or insecurity, to perfectionism, group dynamics, or waiting to be engaged by the facilitator. The important line to walk with “silent” members between putting too much pressure on them to engage or allowing them to become extremely isolated. Group members that lag behind others in sharing details or concerns about their lives may struggle to catch up. Some basic interventions could include commenting on the “silent members” nonverbal behavior, asking other members of the group what silence means to them, or speak about times in their lives where they have found themselves silent (Yalom and Leszcz, 2005).

 “The boring client” is a somewhat arbitrary concept, as “boring” can mean different things to different people. The important thing to look for is a participant that is often restrained, either in affect or verbal/non-verbal involvement with the group. Typically, this person plays it very safe with how they engage other group members and rarely take risks in sharing. They may also be very rigid in their thought patterns and spend inordinate amounts of time on details rather than feelings. This could come out of a serious fear of rejection or abandonment or the belief that bringing forward more of themselves in an assertive manner could be taken as being “too aggressive” (Yalom and Leszcz, 2005). One example Yalom gives is below:

*“One of my clients, Nora, drove the group to despair with her constant cliches and self-deprecatory remarks. After many months in the group, her outside life began to change for the better, but each report of success was accompanied by the inevitable self-derogatory neutralizer. She was accepted by an honorary professional society ("That is good," she said, "because it is one club that can't kick me out"); she received her graduate degree ("but I should have finished earlier"); she had gotten all A's ("but I'm a child for bragging about it"); she looked better physically ("shows you what a good sunlamp can do"); she had been asked out by several new men in her life ("must be slim pickings in the market"); she obtained a good job ("it fell into my lap"); she had had her first vaginal orgasm ("give the credit to marijuana"). The group tried to tune Nora in to her self-effacement. An engineer in the group suggested bringing an electric buzzer to ring each time she knocked herself Another member, trying to shake Nora into a more spontaneous state, commented on her bra, which he felt could be improved. (This was Ed, discussed in chapter 2, who generally related only to the sexual parts of women.) He said he would bring her a present, a new bra, next session. Sure enough, the following session he arrived rived with a huge box, which Nora said she would prefer to open at home. So there it sat, looming in the group and, of course, inhibiting any other topic. Nora was asked at least to guess what it contained, and she ventured, 'A pair of falsies.' She was finally prevailed upon to open the gift and did so laboriously and with enormous embarrassment. The box contained nothing but Styrofoam stuffing. Ed explained that this was his idea for Nora 's new bra: that she should wear no bra at all. Nora promptly apologized to Ed (for guessing he had given her falsies) and thanked him for the trouble he had taken. The incident launched much work for both members. (I shall not here discuss the sequel for Ed.) The group told Nora that, though Ed had humiliated and embarrassed her, she had responded by apologizing to him. She had politely thanked someone who had just given her a gift of precisely nothing! The incident created the first robust spark of self-observation in Nora. She began the next meeting with: "I've just set the world ingratiation record. Last night I received an obscene phone call and I apologized to the man!" (She had said, "I'm sorry, you must have the wrong number.")”*

 “The help-rejecting complainer” does not happen frequently in a complete manner, but can often show up from time to time in many individuals. People operating in this style of interaction will often come to the group with requests for help, but will then move to reject any ideas or advice offered by the facilitator or other group members (Yalom and Leszcz, 2005). This dynamic can quickly become frustrating to the group and the “help-rejecting complainer” will appear to be absorb large amounts of energy. Even though this can be one of the most difficult patterns to work with, there are a couple strategies that can be effective. Typically offering sympathy/empathy reinforces the pattern, so facilitators are better off adopting the participants pessimistic view point, noting the irony of the situation the participant faces, while remaining somewhat detached. There is always a careful distinction to be made between therapeutic play/intervention and simply mocking a participant (be mindful of this). Finally, gradually moving a “help-rejecting complainer” toward empathy with other group members can be helpful in getting them to a point of recognizing their own behavioral patterns (Yalom and Leszcz, 2005).

**Checklist of Session Two Competencies**

The checklist below will be used a competency test for individuals that have gone through the training process. Individuals in training will watch a video of a Vietnam era Veteran sharing his experience of

The facilitator described the following when introducing the empty-chair exercise:

* An issue is described by a participant.
* What follows is a moment of silent reflection.
* The first leader shares a response of what he/she believes God/higher power might be saying.
* The second leader shares a response of what he/she believes God/higher power might be saying.
* Other participants are invited to share their responses (either from the perspective of a higher power or as a fellow human/service member/ Veteran.
* After all participants have the opportunity to respond, the recipient describes what it was like to receive the responses.
* The responders then describe their experience of speaking words they imagined coming from God/higher power.
* Another Empty Chair Technique (with another issue) is facilitated as time and circumstances permit.
* The facilitator’s response encouraged the participant to pursue a reparative relationship with her/his higher power.
* The facilitator engaged the participant in a manner that was “consistent enough” with his/her faith/belief orientation.
* The facilitator was able to discern inappropriate guilt and respond in a manner that did not cause additional harm.
* The facilitator’s response was offered in a nuanced manner that pointed out the complexity of certain situations and encouraged the participant to move out of rigid either or thought/belief patterns.

**Key References (need to be reviewed prior to group facilitation)**

https://www.ptsd.va.gov/

<https://www.youtube.com/playlist?list=PLnh2PvQFlZsnaxU0sPA-8W24OsHxdgqFo>

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1. See the recommended references section at the end of the manual for specific resources to study. [↑](#footnote-ref-1)
2. Another excellent resource is the is the VA Peer Specialist Training Manual. Especially chapters 7-9. A copy can be provided by request. [↑](#footnote-ref-2)
3. Jackie Braughton, MA, Cory Voecks, MA, and Lucas Hansen, MA all contributed to the Relevant Background section. [↑](#footnote-ref-3)