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# The Design and Implementation of a Grief Support Program in a Faith-Based Setting

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The Design and Implementation of a Grief Support Program in a Faith-Based Setting

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### Abstract

Although grief itself is not a pathological condition, adequate support before and after loss can prevent grief becoming unresolved or complicated. Complicated grief (CG) is often diagnosed when severe bereavement symptoms persist over six months following a loss, and it affects an estimated 3-25% of the general population (Fujisawa, Kato, Miyashita, Nakajima, Ito, & Kim, 2010). Complicated grief can result in longstanding psychological issues such as depression and substance abuse.

One group that is at particular risk for CG is older lesbian, gay, bisexual and transgender (LGBT) individuals. This population is significantly represented at Most Holy Redeemer Catholic Church (MHR) in San Francisco, California. Thus, a grief support program with special sensitivity to older gays was designed and implemented at MHR in 2013-2014.

The MHR program included one-on-one counseling, educational venues, healing rituals, and grief groups. Qualitative evaluations of all interventions revealed overwhelmingly positive outcomes. In a Likert scale survey, participants of one of the program's educational events expressed significantly high satisfaction with this intervention. A structured six-week group was evaluated with a paired t-test of pre and post-test Comprehensive Bereavement Index (CBI) scores and a qualitative survey. Although the CBI results were not statistically significant, there was improvement in the pre and post-test results.

The lessons learned from this project will hopefully serve as a resource for MHR and for other faith-based and community programs. Most Holy Redeemer's program has also allowed its facilitators to examine the wider psychosocial needs of MHR and its surrounding community. *Keywords:* grief, bereavement, faith-based nursing, parish nursing, peer counseling, groups, and community mental health programs.

## The Design and Implementation of a Grief Support Program in a Faith-Based Setting

### **Introduction**

Faith Community (FCN) or parish nursing is a relatively new form of delivering nursing care. It is a means of providing holistic care with a spiritual focus within religious communities. Faith Community Nursing is growing exponentially in its frequency of use, functions and models of practice (Dyess, Chase & Newlin, 2010). One reason for the rise of FCN in recent years is a greater access to health care funds given to churches through the advent of Charitable Choice under President Bill Clinton and Faith Based Initiative funding under Presidents George W. Bush and Barak Obama (Kramer, 2010). Parish nursing has also helps bridge gaps caused by the deteriorating US economy and the lack of access to healthcare within certain populations (Dyess et al., 2010).

Numerous studies have documented the positive relationship between spirituality and/or religion on health and wellbeing (Koenig, McCullough & Larson, 2001). Although most of this research deals with physical illness, there is increasing evidence linking religious/spiritual interventions with improved mental health. Literature also suggests that mental health faith-based interventions, including those performed by a FCN, may be effective with a wide variety of patient populations (Tuck, Pullen & Wallace, 2001; Stanley, et al., 2011).

One mental health issue that has been addressed within churches is grief – for although grief itself is not pathology, the ramifications of unresolved grief can be severe. When people do not receive adequate support during bereavement, or cannot come to terms with a loss, they can suffer for years from depression, substance abuse, physical illness and other maladies (Piper, Ogradniczuk, Joyce & Weidman, 2011).

Goodman and Stone (2009) discuss how FCN may have special applicability with the mental health issue of grief. The authors state that increasingly, patients are entering psychotherapy not for the purpose of curing symptoms, but for finding meaning in their lives. Meaning-making seems especially relevant when people face issues such as anxiety, substance abuse, and grief. Formal counseling and psychiatry may alleviate bereavement symptoms; however, complementary treatments such as education, cognitive or art therapy and other interventions that can be performed by a nurse, can also play a part in the healing process (Wittouck, Van Autreve, DeJaegere, Prtzky & van Heerigen, 2010).

The purpose of this project was to create a nurse-led evidence-based grief support program at Most Holy Redeemer Catholic Church (MHR) in San Francisco, California. With the help of volunteer peer counselors, a Doctor of Nursing Practice (DNP) student led the project. In the course of this work, one client population, older LGBTs, emerged as a primary recipient of this intervention. This is perhaps because older gays are not only significantly represented at MHR, they reflect a large demographic with growing psychosocial needs throughout San Francisco. Thus, while making itself available to all MHR parishioners, the grief support program was especially sensitive to the needs of older gays.

### **Background Knowledge**

All humans at some time in their life experience the loss of a loved one. Typical grief reactions include shock, denial, sadness, irritability, insomnia, and yearning for the lost person. When the grief becomes intense and enduring, an individual can suffer comorbid complications such as depression, substance abuse, health problems, and social dysfunction (Piper et al., 2011).

A particular classification of grief known as complicated grief (CG) is diagnosed if serious grief symptoms persist for over six months after a loss (Piper et al., 2011). Unlike the

symptoms of bereavement-induced depression, CG symptoms can persist over time, and are often unresponsive to typical depression interventions such as anti-depressants (Lobb, Kristjanson, Aoun, Monterosso, Halkett & Davies, 2010). Although nurses can assist clients with many types of grief, an awareness of CG is essential when considering bereavement issues. This is because CG exemplifies an extreme form of unresolved grief, and clients with CG may be in special need of support. Complicated grief can also be prevented with early grief interventions (Wittouck et al., 2010).

Current epidemiological studies place CG at 3-25% of the general population, but prevalence shows wide variation depending on social and clinical backgrounds (Fujisawa et al., 2010). Individuals experiencing sudden and unexpected loss, people with dependent personalities, or those who have a history of depression may be at increased risk for CG. Women tend to experience more CG than men, although men are more susceptible to physical problems such as a heart attack or stroke following a loss (Lobb et al., 2010).

### **Local Problem**

Based on existing literature, the population at MHR may be at particular risk of CG. A parish demographics survey (Table 1) taken in 2012 revealed that 43% of the survey respondents were 60 years of age or older (MHR, 2012). Kristjanson, Lobb, Aoun & Monterosso (2006) cited numerous studies indicating that older adults may be at risk for CG. Issues such as limited resources, caregiver burden, involuntary change of residence, and cumulative loss may amplify these risks.

An analysis of 5741 older adults was conducted by Newson, Boelen, Hek, Hofmann & Tiemeier (2011). Of these subjects, 25.4% were diagnosed with CG, and the authors separated



this diagnosis from other issues such as depression and anxiety. These and other findings highlight the need for supportive and preventive treatment for older adults who are grieving.

In addition to noting a large number of seniors, the MHR parish survey also revealed that 49% of parish respondents identified as LGBT or “queer.” Lesbians, gays, bisexuals and transgendered people often suffer from what is known as “disenfranchised grief” (DG). This type of grief is characterized by social stigma, and a lack of recognition, validation, and support for the loss experience. There is strong evidence that people suffering from DG are also at heightened risk of developing CG (McNutt and Yakushko, 2013). Gays may also face challenges when they attempt to find grief support through traditional sources. For example, their relationships may not be seen as valid in support groups or in bereavement ceremonies where families are based on heterosexual norms (Reimers, 2011).

The large gay population at MHR is related to historical and social factors that can further contribute to DG and CG. Most Holy Redeemer exists in the center of San Francisco’s Castro District, an area that has long been a haven for LGBT people throughout the United States. Thousands of gays have migrated to the Castro because of its thriving gay culture and acceptance of LGBTs. This acceptance, which is found in the gay neighborhoods of other large cities, is often coupled with the separation that many LGBTs feel from their families and communities of origin. These losses have been intensified by the estrangement and stigma that can come from being gay, and all of these factors can contribute to DG and CG (Jansen, Casslan & Humbert, 2014).

The AIDS crisis cast a further shadow over the Castro in terms of grief and loss. It was in fact AIDS that prompted gays to fill the ranks of MHR. The church reached out to the individuals who were suffering in its midst, and MHR became a spiritual and physical refuge

during this difficult period. The church consequentially started Coming Home Hospice in one of its buildings, where countless people with AIDS were cared for prior to their death (Godfrey, 2007). Numerous individuals who currently attend the church lived through the worst of the AIDS years, and many lost loved ones to this epidemic.

### **Intended Improvement/Purpose of Change**

Due to its described history, since the 80s, most of the grief interventions done at MHR have centered on AIDS. The church has an AIDS ministry, but with the advent of newer AIDS drugs, most of this work involves supportive care of the living, not specific grief issues related to death and dying.

The church also has a Grief and Consolation (G&C) ministry (separate from the AIDS ministry), but at the time the author encountered the G&C group, it appeared to be faltering in its purpose and function. Members of the ministry were being sent through a training that was presented by the Catholic Diocese of San Francisco, but the training was not being put into practice. In addition, for a variety of reasons, volunteers began to drop out of the ministry. One of the main reasons people were leaving was that there was a shortage of volunteers to serve in most ministries at MHR. Parishioners were feeling burnt out in general with all of the work that needed to be done in the church.

In late 2013 and early 2014 the G&C Ministry conducted a parish needs assessment regarding grief support (Table 2), which was distributed at various parish events. The needs assessment indicated that of those surveyed (n=49), 48% were interested in rituals, 72% wanted educational programs, 24% sought individual peer counseling, and 38% expressed interest in grief groups. Of those drawn to groups, 38% wanted drop-in groups and 85% preferred a

structured group of between six to eight sessions. (Note – respondents could give more than one preference for any category).

It appeared that there was significant interest in all categories, with the highest need for educational venues and rituals. This mirrors previous research that suggests that those needing mental health care may be reluctant to identify those needs, either within themselves or to their parish (Dossett, Fuentes, Klap & Wells, 2005; Prickett-Schenk, 2005). Thus, a direct request for help (either with a grief group or one-on-one counseling), may be overshadowed or preceded by a need to gather information through educational forums, or to participate in a more collective event like a ritual.

The 2012 parish demographic survey (Table 1) revealed that a significant number of parishioners were at risk for CG. As noted, the congregation has large populations of LGBTs and people over 60, both of which are high CG risk categories.

Based on the data gathered in the parish needs assessment, and requests by parish members for increased grief support, the author worked with the G&C volunteers to improve and further develop the G&C program. In conjunction with the G&C team, the author arrived at the following plan for the program's improvement:

1. Provide effective leadership for the program based on the skills acquired at the DNP level.
2. Recruit more volunteers and train them in an evidenced-based and cost-efficient manner.
3. Provide evidence-based interventions for the bereaved including one-on-one peer counseling, educational venues, healing rituals, and grief groups.
4. Collaborate with other ministries in order to build networks of increased support for the G&C and all church ministries.

## **Review of the Evidence**

**Search strategy.** The literature supporting this project was divided into three domains. Data bases used for all domains included the Cumulative Index of Nursing and Allied Health Literature (CINAHL), Psych Info, PsychARTICLES, PubMed, and Google. The search filters included English-only peer-reviewed journals spanning the years 2000-2014.

There was an overlap of key search terms in all domains which included: grief, disenfranchised grief, complicated grief, faith-based nursing, parish nursing, peer-counseling, grief groups, bereavement and grief support programs, peer support, faith-based, parish, and community mental health programs.

**Domain one.** The first domain examined the issue of implementing a mental health peer-support program in a community setting. The initial search was for studies that dealt exclusively with grief programs in faith-based settings, however there was limited literature that discussed mental health (let alone grief) programs in churches. Thus, the search was expanded to address mental health interventions in the community. Some of the cited studies did include churches, but most were in other community settings. The topic of “peer-led” was chosen, because the author wanted to design a program that did not necessarily require licensed therapists. (The G&C Ministry did agree however, that if a licensed therapist voluntarily offered his or her service to the project, this service would be welcomed and utilized).

**Domain two.** The second search domain explored the topic of peer-led grief groups. This subject was selected because group support often appeared more beneficial than other bereavement interventions (Piper et al., 2011).

**Domain three.** Peer-counseling techniques were evaluated in the third domain. This search revealed that although much literature exists on peer counseling (both one-on-one and in

groups), studies that defined specific peer counseling methods were difficult to find. Most studies primarily documented the outcomes of peer-counseling interventions. Since the author needed to teach and practice peer-counseling techniques, during this search, she mostly relied on non-research sources.

**Evidence model.** The Johns Hopkins Nursing Evidence-Level and Quality Guide (Dearholt, Dang, Institute for Johns Hopkins, Johns Hopkins, & Sigma Theta Tau, 2012a) was used to evaluate the articles in domains one and two, and one of the sources in domain three (Table 3). The John Hopkins Nursing Non-Research Evidence Appraisal Tool (Dearholt, Dang, Institute for Johns Hopkins, Johns Hopkins, & Sigma Theta Tau, 2012b) served to evaluate the non-research sources in domain three (Table 4).

**Domain one evaluation.** In this systematic review, the question was asked, “How can peer-support mental health programs help adults in a parish and/or community setting?” The following PICOT format was used: population: adults in a community setting; intervention: peer support mental health; control: compared to other or no intervention; outcome: decreased mental health symptoms; and time: not specified.

Seven studies were analyzed in this review. The studies’ strength and quality of evidence are illustrated in Table 5.

***Community mental health peer support programs.*** In the field of mental health, peer support has taken many forms. Common examples are recovery self-help groups like Alcoholics Anonymous, or more structured groups such as those offered by The National Alliance on Mental Illness (NAMI). Definitions of peer support included “a system of respect, shared responsibility, and mutual agreement of what is helpful” (Mead et al., 2001, p. 135). Barlow, Waegemakers, Chugh, Rawlinson, Hides and Leath (2010) defined peer support as “the social,

instrumental, or emotional support that persons sharing similar life challenges or circumstances provide to each other in reciprocal fashion” (p. 917).

Solomon (2004) explained the underlying process of peer support in five theories: social support (knowing people care about the person seeking support), experiential knowledge (the sharing of lived experiences), helper-therapy principle (the benefits derived from helping others), and social learning principle (people serving as role models for healing).

McCorkle, Dunn, Wan, and Gagne (2009) found that a peer support community mental health program helped people with mental illness increase their social networks, improve their ability to function, and overall improve their quality of life.

When assessing clients with re-occurring substance abuse and mental health problems, So-Young, Whitecraft, Rothbard, and Salzer (2007) found that clients in a peer support program were re-hospitalized less over a three-year period (62% compared to 73%) than those who were not in a program. The peer support program was also associated with fewer hospital days.

Providing peer support has enhanced social, spiritual, emotional, and occupational outcomes for volunteers. For organizations, using peer volunteers has not only been financially advantageous (Handy & Mook, 2010), it has increased levels of public support, decreased staff workload, and improved the quality of services (Moran, Russinova, Gidugu and Gagne, 2013).

Moran et al. (2013) also noted some negative aspects of peer programs. These included role confusion, breaches of confidentiality, and conflicts between volunteers and recipients of support. In addition, the authors found deficits among peer volunteers in the areas of education, training, and supervision.

***Summation of studies.*** In reviewing the selected studies in this systematic review, several themes emerged. These included: a) the church as a mental health resource; b) funding

and outreach; c) the use of service as a therapeutic intervention; d) matching clients with similar needs; and e) and limitations of peer support in community mental health programs.

*The church as a mental health resource.* Both Dossett et al. (2005) and Pickett-Schenk (2002) saw churches as a viable means of providing community mental health care. The available resources within churches (such as meeting spaces, personnel, and funding) provided structure for mental health interventions. Parish fellowship, a familiar environment, and a church's spiritual overtones, also played a role in helping clients cope.

*Funding and outreach.* The need for adequate funding was a recurring theme in several of the studies. Dossett et al. (2005), Fajgebalum et al. (2012) and Kotecki (2002) recommended forming partnerships with other professional organizations as a way of alleviating costs. Some of the studies in this domain highlighted the difficulties in recruiting clients for programs. Pickett-Schenk (2002) found that the most successful outreach efforts came from the church bulletin, a scheduled mental health workshop, and word-of-mouth. The author also found that providing childcare and transportation increased program attendance. Additionally, there were issues cited around clients not being able to recognize their own needs for the provided services. The facilitators felt it was important to educate parishioners on how the program could prove helpful. Fajgebaum et al. (2012) introduced the idea of using social media to recruit college students. As possible recruitment factors, Barlow et al. (2010) cited flexibility in meeting times and neutrality in meeting places.

*The use of service as a therapeutic intervention.* Fajgenbaum et al. (2012) utilized the practice of service in helping college students heal from loss. Volunteering for activities like cancer walks, or visiting a children's hospital, gave students a positive outlet for their grief and a means for building social support.

*Matching clients with similar needs.* Barlow et al. (2010) suggested that matching clients with similar needs or losses was helpful in a suicide survivor program. Similar peer support findings were revealed in Spencer et al. (2013).

*Limitations of peer support in community mental health services.* In many of the studies, challenges arose in relying on peer support for mental health care. In Barlow et al. (2010), peer counselors discussed their inability to establish proper boundaries with clients, to elicit client responses, and to terminate interactions. Fajgenbaum et al. (2012) spoke of student leaders' lack of knowledge in handling some grief situations and the risk that volunteers may lead groups in a harmful way. In both of these studies, as in Ho (2007), the authors discussed the need for back-up professional consultation, and the proper training of peer counselors. The authors also recommended that the training should include knowledge of when to refer clients to higher levels of care, and how to access those care resources.

**Domain two evaluation.** In preparation for this search, the question was asked: "What are optimal supplemental (as opposed to licensed) community group therapy interventions for adults who have experienced loss?" The following PICOT format was used: population: adults in a community setting; intervention: complementary group therapy; comparison: comparison of other therapies or control (no therapy); outcome: decreased bereavement symptoms; time: not specified.

There appeared to be limited research that addressed the implementation of FCN grief support groups, however, complementary group grief support was documented in several community settings. Five studies were analyzed with Dearholt et al. (2012a). The strength and quality of this evidence are illustrated in Table 6.



*Summation of studies.* Many insights were gathered from the domain two analysis. These insights can be organized into the following categories: a) peer support; b) education; c) transcendence and meaning-making; and d) miscellaneous factors.

*Peer support.* It appeared that the support of other group members was especially important to the subjects in most of the studies. People spoke about the need for practical and tangible support, and the value of having others who could listen without judgment. Group members also found solace in knowing that they were not alone in their grief, and members often role-modeled ways in which grief could be dealt with (Eagle, Creel & Alexandrov, 2012; Olson & McEwen, 2004; Steiner, 2006).

*Education.* Learning about grief processes and coping skills appeared to be very important to many of the subjects. In Olson and McKewen (2004), group members appreciated being given “homework” or in-class assignments that helped them understand their grief. Steiner (2006) also emphasized the value of interactive assignments for groups. In addition, Steiner (2006) indicated that there needed to be more general education about the purpose of grief groups, as many individuals did not see groups as valuable, or considered attending groups as a sign of weakness.

*Transcendence and meaning-making.* Several of these studies spoke to the role of finding meaning in loss. In Cacciatore (2007), more than half of the women studied who had experienced a stillbirth, expressed comfort in reaching out and helping others. Steiner (2006) indicated that positive religious and spiritual perspectives were associated with increased coping with less hopelessness following loss. This reflected previous work, as in a systemic review of 40 randomized control studies; the subjective interpretation of loss (or the inability to find

meaning in a loss) greatly outweighed all other risks factors associated with CG (Lobb et al., 2010).

Although Spirituality is seen as part of transcendence in several of the studies, Goodman and Stone (2009) cautioned that there might be a difference between positive and negative religious experiences. The authors concluded that negative religious and spiritual coping (such as excess guilt) could in fact impede recovery from grief. Thus, facilitators needed to be alert to any negative religious perspectives from clients, and help these people reframe their perspectives. For example, seeing God as loving and forgiving (rather than judging) was beneficial to study participants.

*Miscellaneous factors.* Numerous miscellaneous factors can be garnered from these studies, including the issues that come up in “mixed” loss groups. Respondents in Steiner (2006) voiced a need to meet with others who shared a similar loss. The researcher also stressed the value of logistics. It was important to plan convenient group times and when possible, assist members with transportation issues. Furthermore, Steiner (2006) discussed the fact that the bereaved need ongoing support, and that many times support resources “dry up” after the initial time of loss. The study’s findings indicated that groups should acknowledge the need for support, even years after a loss.

Olson and McKewen (2004) highlighted the importance of confidentiality and of keeping the group discussions on track. Participants in the Olson and McKewen (2004) study were also carefully screened for their appropriateness for the group.

**Domain three evaluation.** This review sought to explore ways in which a non-therapist, or peer counselor might support someone who is grieving. The question was asked: “Which peer-counseling techniques can be utilized in a community setting both in groups and in one-on-

one sessions for clients with mental health issues?” The following PICOT format was used in this search: population: adults; intervention: peer support; control: compared to no intervention; outcome: decreased mental health symptoms; and time: not specified.

Twenty sources were uncovered in this search, and evaluated with Dearholt et al. (2012a; 2012b). The strength and quality of these studies can be viewed in Table 7.

During this search, the following categories emerged: a) one-on-one counseling; b) cognitive behavioral therapy (CBT); c) leading groups; and d) addressing disenfranchised grief.

***One-on-one counseling.*** Many of the basic tools used in peer counseling were derived from Washington State’s Division of Behavioral Health & Recovery (WSDBHR, 2009). These techniques centered on cultivating relationships, communication skills, instilling hope, empowering people through building on their strengths, and helping individuals with self-advocacy. The authors also discussed how to recognize barriers to healing as well as signs of recovery. In addition, WSDBHR (2009) addressed legal or ethical issues that might arise in one-on-one counseling.

***Cognitive behavioral therapy.*** Perhaps because CBT can provide such an effective and “user friendly” framework for peer counseling (both one-on-one and in groups), CBT repeatedly emerged in the search process. Definitions of CBT came from Calvert and Palmer (2003), Currier, Holland, and Neimeyer (2010) and Corey, Corey & Corey (2014). Humphrey (2009) discussed how CBT can be applied to the specific topic of grief.

Socratic questioning, a CBT technique, was explored in Brook-Harris (2001) and Overholser (2013). Thought stopping, another CBT technique, was addressed in Humphrey (2009).

Ritual, client education, and assisting the bereaved through the creative arts, were all linked to CBT. Humphrey (2009) saw ritual as a powerful cognitive tool for providing meaning after a loss. Similarly, other authors indicated that writing feelings down could modify core beliefs and help shape a client's views (Beattie, Shaw, Kaur, & Kessler, 2009; Wenzel, Brown & Karlin, 2011). The same was said about the visual arts, and Humphrey (2009) suggested ways to cognitively reframe feelings around a loss through the use of collage, painting, drawing, and viewing photographs.

**Leading groups.** Piper et al. (2011) compared structured to drop-in groups and listed the advantages and disadvantages of each. The authors also discussed screening clients for a structured group, including suggested inclusion and exclusion criteria. Both Corey et al. (2014) and Yalom and Leszcz (2005) delved deeply into group therapy techniques, including theoretical models, group cohesion, leadership qualities, giving feedback, dealing with conflict, problem members, and closing a group.

**Addressing disenfranchised grief.** Doka (1989) and Corr (2002) defined DG and broke it down into categories. Populations at particular risk for DG were explored by several authors including Reimers (2011), and McNutt and Yakushko (2013), who discussed DG and LGBTs; and Doka and Aber, (2002) who described psychological loss which can occur when a person remains living, but relevant aspects of his or her personality are gone (such as with Alzheimer's disease or alcoholism). Kaufman (2002) examined the topics of self-disenfranchisement and shame, and Reynolds (2002) raised the issue of the politics of DG. Methods for healing from DG were introduced by Neimeyer & Jordon (2002), Doka (2002), Corr (2002), and Todd (2011).

Todd (2011) linked DG with liberation psychology and liberation theology. Liberation psychology involves examining the political, historical and social forces that may influence an

individual's psychological symptoms. Similarly, liberation theology involves viewing spirituality through a political or sociological lens. A well-known example of liberation theology occurred in black churches during the civil rights struggle. At that time, African Americans used Christian teachings that were based on nonviolence to bring about social change. Within this process, they were also able to look at ways in which societal racism had adversely affected the way they viewed themselves (Todd, 2011).

Todd (2011) suggested that liberation psychology and liberation theology could be used in conjunction with one another. Both liberation psychology and theology focus on consciousness raising and praxis (action). Once praxis has taken place, the experience will lead to reflection and further consciousness raising, and again, more action. Todd (2011) saw churches as ideal settings for the integration of liberation theology and community psychology.

### **Conceptual/Theoretical Framework**

Three theoretical models helped frame the MHR project. The ministry used Worden's (1991) Tasks of Mourning and Stroebe and Schut's (2010) Dual Process Model (DPM) in assisting clients with the mourning process. In addition, Cognitive Behavioral Therapy (CBT) was used to assist clients in one-on-one counseling, in groups, and as a framework for grief rituals.

**Worden's (1991) Tasks of Mourning.** Worden's (1991) Tasks of Mourning were used as a theoretical framework for one-on-one counseling and grief groups. This model proved to be efficient and easy to use, especially for non-therapists. Worden's (1991) tasks are listed as follows:

1. To accept the reality of the loss.
2. To experience the pain of grief.

3. To adjust to an environment in which the deceased is missing.
4. To emotionally relocate the deceased and move on with life.

**Dual Process Model.** Stroebe and Schut (1999) suggested that Worden's (1991) model might be limited. The authors explained that the process of grief in this model appears passive – as if the bereaved is being “put through” rather than actively dealing with his or her loss. In addition, there is no acknowledgement for the “dosing” of grief. Stroebe and Schut (2010) proposed that the work of grief requires respite at times, and the bereaved periodically need to withdraw from grieving tasks. The authors also suggested that Worden's (1991) work did not address the benefits of denial. Finally, Stroebe and Schut (2010) felt that Worden (1991) primarily focused on the loss itself, neglecting other stressors that arise during bereavement (e.g. financial, legal, etc.).

For the aforementioned reasons, Stroebe and Schut (1999) introduced The Dual Process Model of Coping (DPM) as a grief theory. With the DPM, loss adaptation is a fluctuating process of both emotionally confronting a loss, and also moving on with other life experiences and responsibilities. These two processes are called loss and restoration orientations (Humphrey, 2009). The DPM was used in this project to supplement Worden's (1991) tasks in dealing with clients' grief.

**Cognitive Behavioral Therapy.** Calvert and Palmer (2003) proposed that in CBT, there is a causal relationship between someone's thoughts and beliefs and his or her emotions. Thus, if thoughts and/or beliefs can be altered, the feelings that follow these cognitions can also change. Cognitive Behavioral Therapy was employed in both one-on-one counseling and group therapy with clients in this program, and the technique was reflected in educational venues, assigned writing assignments, and grief rituals.

## Methods

### Ethical Issues

The University of San Francisco determined that this was a quality improvement project. Since this project did not include research on human subjects, it did not require full internal review board approval.

The Catholic Diocese of San Francisco trained members of the G&C Ministry who worked with clients. The author also instructed the volunteers based on the information found in Mortell (2014). Both of these sources emphasized the ethical issues of confidentiality, personal boundaries and the avoidance of bias. Volunteers were additionally instructed to notify the program administrator if it appeared that a client intended to hurt him or herself, or if there was a purported danger to a child or dependent adult.

Recipients of any form of grief counseling by the ministry (either one-on-one or group) were told that the counselors were not licensed therapists, but rather peer volunteers (excluding the program's one structured group, and the second drop-in group, both of which utilized licensed therapists). Subjects were also referred to higher levels of care if it appeared that they needed support that went beyond what could be provided in the peer-counseling program. For legal and ethical reasons, the ministry did not endorse any particular provider, but rather gave the clients a list of available providers from which the clients themselves could choose.

All clients were informed that despite the program's pledge of confidentiality, counselors would need to report to a church administrator any perceived or actual danger to a client, to someone else, or any abuse of a child or dependent adult.

Applicants for the structured grief group were screened with inclusion/exclusion criteria (Appendix A) based on Piper et al. (2011). Once invited to participate, group members signed a

confidentiality agreement. This signed contract also acknowledged that participants were free to leave the group at any time (Appendix B).

### **Setting**

As noted, MHR is located in San Francisco's Castro District. Although its demographics are changing, and the church welcomes people of a wide array of ages, races, and sexual orientations, a significant portion of the church's population is over 60 and LGBT. People who participated in the G&C Ministry activities were also mostly older gays. These demographics contribute to many issues that have already been discussed and will continue to be explored. Such issues include the high risk of DG within this group, and also the strong feeling of camaraderie that can take place when disenfranchised people gather together.

Since many gays find it difficult to get their needs met in traditional therapeutic venues (McNutt & Yakushko, 2013), the grief program was advertised as "LGBT friendly." And although the program was inclusive to all demographic groups, the G&C Ministry strived to cultivate special sensitivity to the needs of older LGBTs.

### **Planning the Intervention**

In conjunction with the G&C Ministry, the author began this project with a parish needs assessment (Table 2). This assessment helped indicate the types of grief interventions that parishioners preferred.

The author also consolidated evidence-based literature regarding the planning and implementation of a grief program, and produced a teaching manual (Mortell, 2014) for nurses and other mental health advocates. Although the ministry had already received training from the Diocese of San Francisco, Mortell (2014) offered additional insights into this type of work.



**Implementation**

**2013.** The G&C Ministry was able to provide the following interventions in 2013: Two “Days of Remembrance” rituals and a drop-in grief group. Members of the parish, including the parish administrators, also began to refer clients to the ministry for one-on-one counseling. These clients were identified as people who had suffered a recent loss, or people who appeared to be in distress around some grief issue.

**2014.** In 2014, two more Days of Remembrance took place. In April of 2014, the ministry also implemented a structured six-week grief group. The one-on-one counseling referrals continued to come in during 2014, and in fall of 2014, the ministry once again reinstated a monthly drop-in grief group.

Other interventions by the ministry in 2014 included four educational events. The G&C Ministry, in collaboration with the church’s Education and Centering Prayer Ministries, sponsored the first three events between January and April 2014. Two of the events were Saturday morning workshops featuring a series of videotaped lectures by Father Thomas Keating OCSO. Keating is a proponent of “Centering Prayer,” a form of meditation that is practiced by many MHR parishioners. In the DVDs, Keating discusses the connection between meditation and death. The DVDs were broken up into sections and in between sessions, the audience engaged in moderated discussions on the DVDs’ content.

A third event involved a presentation and grief workshop by Sister Marian Castelluccio OP. Sister Castelluccio is a social worker and Dominican nun who works with the survivors of shooting deaths in Oakland, California.

In November of 2014, the ministry invited David Richo, PhD., MFT to speak on the topic of grief and spirituality. Richo is a writer, psychotherapist, and teacher whose work combines Buddhist, Jungian, transpersonal, and mythic perspectives.

### **Planning the Study of the Interventions**

**One-on-one peer counseling.** A case study was used to analyze the one-on-one sessions. Another type of analysis may have been too intrusive, given the sensitive nature of these counseling sessions. A case study is also well suited for analyzing something as complex and individualized as one-on-one counseling. Cronin (2014) described case studies as “the social research equivalent of the spotlight and microscope” and suggested that case studies “can take us to places where most of us would not have access or the opportunity to go. They provide enriched experiences of unique situations” (p. 20).

**Rituals.** As with the one-on-one counseling, the clients’ ritual experiences were of a sensitive and personal nature. Because of this, the clients were not evaluated. A focus group analysis however was done with members of the G&C Ministry. A focus group format was chosen because of its benefits in interviewing a number of people in a short time. Focus groups also have the advantage of allowing subjects to hear and respond to opposing viewpoints and generate new ideas that might not have been revealed using other forms of data collection (Plummer-D’Amato, 2008a).

Random selection is not required with focus groups, as this method does not necessarily make inferences about a larger population. Rather, a focus group can be used when participants have a common interest in a particular topic, and the situations involved in focus groups are often firmly contextualized (Plummer-D’amato, 2008a). The purpose of the G&C focus group was to evaluate the rituals held at MHR alone, and there was no need to establish transferability.

**Educational events.** The ministry wanted to know how audiences perceived the educational events, and how the team could improve these venues. Thus, a quantitative and qualitative survey was chosen. The evaluation was done on the first Keating workshop.

**Drop-in groups.** In regards to the drop-in groups, only two people showed up for one of the four monthly sessions in the 2013 series. These clients were not evaluated; however they did say they appreciated the group and found the session valuable. They also said they wished the group was happening more frequently (but did not show up for subsequent groups). Although no formal evaluation was done for either the 2013 or 2014 series, the ministry collectively concluded (after the first series), that they should have put more effort into advertising and outreach.

Richard Wanner PhD (personal communication, July 9, 2014) is a licensed therapist who was consulted on this project. He advised the ministry to use caution in its advertising for the 2014 drop-in groups. Since drop-in clients would not be screened, Wanner suggested that the ministry advertise through local parishes or other structured organizations. This would attract clients who were already involved in some organized activity. Wanner felt that putting flyers on the street or in a local gay newspaper (as was suggested) would increase the chance that people who were inappropriate and possibly disruptive to the group might attend. Wanner's proposal was thus followed, as was his suggestion that the ministry use co-leaders for the drop-in groups. This would give leaders added support.

**Structured group.** Based on the results of the parish needs assessment, the G&C Ministry decided to implement a structured grief group at the church. The group was organized around the recommendations presented in Mortell (2014) and took place at the church in six 90 minute weekly sessions between April 1 and May 6, 2014.

The group was inclusive in that it was secular (not religious) and did not restrict its members to a specific gender, type of loss, or sexual orientation. However, the group was advertised as LGBT Friendly. In other words, gay relationships were openly acknowledged and valued in the group, and issues around DG and gays were explored. In addition, each co-leader of the group had extensive knowledge of the specific grief needs of LGBT people.

***Selection process.*** Recruitment for the group was done via the following methods: a notice was placed in the church bulletin, a Catholic newspaper, a local non-denominational gay church, San Francisco's LGBT Community Center, a mental health outpatient clinic, a lesbian email list serve, a gay men's email list serve, and on a local gay radio program. Announcements regarding the group were made at various parish events and a poster about the group was placed in the church hall, which serves as a meeting place for a senior center, a soup kitchen, and several Alcoholics Anonymous meetings.

Most of the inquiries regarding the group came from the lesbian list serve. This was possibly because lesbians may have less access to mental health care than men or heterosexual women (American College of Obstetricians and Gynecologists, 2012), and women in general are more likely than men to seek out mental health services (Vogel, Westen & Larson, 2007).

Socio-economic and gender factors may have also figured into the fact that only three applicants came from MHR itself. According to MHR's 2012 Parish demographic survey (Table 1), MHR's population is predominantly male. Most Holy Redeemer is also located in a relatively affluent part of San Francisco, and visually surveying parishioners at parish Masses reveals a congregation that is mostly white. Per the literature, people's race and income are highly correlated with mental illness risks and an individual's ability to access mental health

care. Populations with less income and people of color encounter more mental health disparities (Center for Disease Control and Prevention, 2011).

Prior to the start of the sessions, perspective clients contacted the author expressing an interest in the group. The author, who also served as a co-leader, then met with perspective clients to determine their appropriateness for the group. Their acceptance to the group was based on the inclusion criteria as outlined in Appendix A. The author evaluated the applicants through open conversation about their lives, loss, and experiences with mental health services. If the interviewees did not meet the inclusion criteria, they were given other resource referrals.

Once selected, clients were asked to sign a contract (Appendix B), which outlined the group's ground rules. In the end, six women were chosen for the group. All but one of these women self-identified as a lesbian.

***Group structure and theoretical framework.*** Although this group was originally designed around a peer-support model, a licensed therapist volunteered to co-lead the group along with an experienced psychiatric nurse. The format was open discussion using the therapeutic tools found in CBT and process groups. The group was supplemented with guided meditations and with homework assignments derived from Rich (2001) and Humphrey (2009) which centered around Worden's (1991) Tasks of Mourning. Worden's (1991) tasks were also used as a theoretical framework for the group itself. In addition, group members were taught about Stroebe and Schut's (1999) DPM.

### **Methods of Evaluation**

**One-on-one peer counseling.** One case was chosen which seemed to represent some main similarities in many of the one-on-one peer counseling sessions that the author experienced. The chosen case also illustrated the usefulness of current literature surrounding one-on-one

counseling. To ensure confidentiality in this study, key identifiers were changed. Beyond this precaution, the author did try and record as authentically as possible, what took place in the one-on-one session.

After recording the interaction in a narrative form (from the author's memory), the author identified patterns that were repeated in the one-on-one sessions that she had witnessed with other clients. She also noted how these patterns were reflected in the literature.

According to Cronin (2014), in using case studies, one looks for similarities or differences between cases. If cases are similar, and if they reflect what is revealed in the available literature, the studies raise confidence in the observed phenomena and intervention.

**Grief ritual focus groups.** It is recommended that focus groups occur in a series. There is no recommendation on the numbers of groups that should be evaluated, however saturation of data can influence how many times a focus group is repeated (Plummer-D'Amato, 2008a). Since most of the conclusions collected in the second group mirrored the first, only two focus groups were conducted to evaluate the MHR grief rituals.

Focus groups are considered to have high validity when group members feel comfortable expressing opposing views with one another. Conversely, if group members engage in censoring (withhold their views) or conforming (moderate their views to conform to the majority opinion), the validity, as well as reliability and confirmability of results can be compromised. This is because the more that individuals share common backgrounds, the less inclined they will be to hold back their views (Plummer-D'Amato, 2008b).

Censoring and conformity did not seem evident in the G&C group. This could have been because there was a lot of homogeneity in the C&C Ministry. All of the members considered themselves Catholic, all were over 40, and most identified as LGBT.

The author of this project moderated the group and also collected the data. Arguments for moderators collecting data suggest that the moderator needs to have background knowledge on the topic being discussed. To prevent bias however, the moderator must be careful to not let his or her views influence the data's objectivity. The moderator should also make sure everyone in the group has an opportunity to speak (Plummer-D'Amato, 2008a). Special attention was paid to these conditions in the G&C meetings.

**Educational events.** The first Father Keating workshop was evaluated with a Likert scale survey based on Rattray and Jones (2007). The survey was passed out to the participants following the close of the workshop. On the survey were also two qualitative questions: "What worked?" and "What could be improved?"

**Structured group.** Although there are several tools to consider when designing a structured grief group, there may be few that assess grief's impact on the multidimensional aspects of a person's physical and psychological health. In considering such instruments, Tomita and Kimatura (2002) emphasized that three important aspects of psychometric validity be addressed: factorial, discriminate, and content validity.

In regards to discriminate validity, research indicates that grief is often followed by physical or psychiatric illness. Some tools measure symptomatic clusters; however few can predict the onset of a bereaved person's somatic disorders. Measures can also not always differentiate between normal and CG (Tomita & Kimatura, 2002).

With content validity, the aim is to differentiate "grief-specific" symptoms from other psychological issues such as stress, anxiety or loneliness. Ideally, a measure should differentiate grief from other states (Tomita & Kimatura, 2002).

As a final point, in using a screening tool with the bereaved, Tomita and Kimatura (2002) recommended a short-form survey (between 20 to 30 items). Such tests are easy to administer, and decrease the psychological burden of having clients answer too many questions about negative feelings in recalling their grief.

***Comprehensive Bereavement Items.*** Based on the above recommendations, the Comprehensive Bereavement Items (CBI) tool seemed worthy of consideration. In its short form, it consists of 17 questions. It helps determine the longitudinal changes that can take place after a loved one's death, and it also considers the onset and duration of CG (Tomita & Kimatura, 2002). In terms of discriminate validity, when using the CBI, people who were expected to score at a high risk for CG, did so (Burnett, Middleton, Raphael & Martinek, 1997). The scale demonstrated high reliability (Cronbach's alpha coefficient of 0.91) and sound face validity (Kristjanson et al., 2006). In addition, the CBI is based on factor-analyzed item pools (Tomita & Kimatura, 2002).

For the above reasons, the CBI was chosen as an instrument for the structured grief group. A copy of the CBI appears in Appendix D (Burnett et al., 1997).

### **Analysis**

**One-on-one peer counseling case study.** As indicated, the chosen case study reflected similar experiences that the author had with clients in other one-on-one peer counseling sessions. As part of the case study analysis, the author described the case study in a narrative form. She also summarized the similar themes that she found in other interactions and how these themes were supported by the literature.

**Grief ritual focus groups.** Focus group discussions were conducted following the November, 2013, and May, 2014 Days of Remembrance rituals. Focus group member were those



people in the G&C Ministry who helped organize and present the rituals. Six members participated in the first focus group and four members participated in the second. According to Plummer-D'Amato (2008a), focus groups should ideally contain six to eight members. Smaller groups can lead to insufficient interaction or the reluctance of some to challenge a more dominant member. Larger groups may prevent participation from all members. Small groups may be suitable if the aim of the group is to gain in-depth insights. Small groups are also applicable when members have a lot of experience in the area of analysis.

Small groups were used for this project because the author had to rely on convenience samples. The groups could only involve members who showed up to discuss the ritual events. Fortunately, at least by the second group, the ministry had extensive experience in implementing the rituals (having already conducted three). Saturation occurred because what was discussed in the second focus group mirrored the conclusions from the first focus group.

The discussions in the focus groups were not transcribed. Rather, the author took notes about what occurred and re-wrote the notes within a week of each discussion. Similar themes emerged in both focus groups, and the author and other ministry members agreed upon these themes.

**Educational event.** The mean scores of each quantitative question were recorded. The qualitative questions were collectively evaluated by the team that organized the educational event. Together, the team reached a joint conclusion on the comments' emerging themes.

**Structured grief group.**

**Quantitative analysis.** Participants were administered the CBI before the first group session, and at the end of the last session. The women took the pre-test CBI on the day of the first session before the session began. The women were randomly assigned numbers and told to

place their number on the pre-test. The women placed the same number on the post-test, which was administered immediately following the last session. No one involved with evaluating the tests knew which number had been assigned to which participant. All six women completed both the pre and post-tests. The pre and post-test mean scores were calculated and then compared with a paired t-test.

***Qualitative analysis.*** In addition to the pre and post-tests, the women were encouraged to answer the qualitative questions: “What did you find helpful in this group?” and “What elements in this group could be improved?” These questions were collected via SurveyMonkey®, which was emailed to the women immediately following the last session. Participants were also invited to answer the questions in written form if they did not want to use a computer. Forms with the qualitative questions were passed out during the last meeting along with stamped envelopes addressed to the lead group facilitator. The women were asked to anonymously fill out the survey within two weeks after the final group. The same questions were posed to the two group facilitators.

All responses to the qualitative questions were returned via SurveyMonkey®. The results were reviewed by two people who were not directly associated with the grief group. The reviewers were DNPs who had been trained in qualitative analysis. The DNPs consolidated these results into emerging themes.

## **Results**

### **Program Evaluation/Outcome**

**One-on-one peer counseling.** Below is a description of the chosen one-on-one case study, and a summation of its emerging themes:

J.B., a 62 year-old African-American female, reached out to the author after she heard the author speak at a parish event. J.B. was especially interested in what the author had said at the event about complicated grief. She asked the author if the two could speak privately, and an appointment was arranged. The two then met for a two-hour session.

J.B. described herself as bisexual, and said that twenty-two years earlier, her female partner at the time had hung herself in the garage of the home that the two had shared with J.B.'s daughter. The daughter (who was ten years old at the time) was the first person to find the girlfriend dead. J.B. had suffered for years around the trauma surrounding this event. She felt responsible for her partner's death, as the two had been arguing prior to the suicide. In addition, she felt very guilty about her daughter's experience, and J.B. claimed that to this day, her daughter had not recovered from what she had witnessed. J.B. also said that members of J.B.'s family, including her own mother, had not forgiven her for bringing this woman into J.B.'s daughter's life. The mother was religiously opposed to the couple's homosexual relationship, and J.B. revealed that the girlfriend had been addicted to freebase cocaine, causing further trauma in the family even prior to the suicide.

J.B. said she had been sporadically involved in formal therapy in the years following the suicide and at one point joined a suicide survivor's group. "I was afraid to talk about the gay issue in the suicide group," she said, and "most of the therapists that I saw were useless." She also said that one therapist was "terrible." For one thing, J.B. believed that the therapist was either homophobic or very uninformed about gay issues. She described her visit with this therapist as extremely traumatizing.

"The better therapists mostly helped with other problems I was dealing with," J.B. explained. "I don't think I'll ever get over what happened with the suicide." J.B. said she thinks

about the suicide almost every day and can't seem to forgive herself for what happened. She also said that her current job did not offer health insurance, so she didn't presently have resources for formal counseling.

During the one-on-one session, the author practiced what she had learned about peer counseling. She slowly attempted to build trust and rapport with J.B., engaged in active listening, and shared personal experiences that may have related (if even in a minor way) to what J.B. was going through. The author also discussed what she had learned from the literature in regards to disenfranchised grief.

Since J.B.'s loss involved suicide, drug addiction, and a gay relationship, J.B. admitted that there was a lot of shame associated with the event, and she had been unable to openly discuss what had happened with many people. J.B. also perceived that there was stigma regarding suicide and homosexuality among African Americans. "Many blacks think that only white people are gay, and that suicide is something only white people do," she said. "They say that if someone commits suicide, they are weak." All of these factors seem to limit J.B.'s available social support.

J.B. had grown up in a predominantly African American community that was seriously affected by the crack cocaine epidemic of the 1980s and 90s. (The suicide occurred in that community in 1992). In the one-on-one session, the author and client discussed the significance of the crack epidemic and its historical, social, and political implications. J.B. stated that cocaine had been "dumped" into poor neighborhoods by people who were totally outside of those communities. She also saw drug dealing as inevitable in her neighborhood, as there were so few other economic opportunities. "Freebase cocaine was everywhere," said J.B., "and once my girlfriend was hooked, she couldn't quit." J.B. verbalized that her girlfriend had been the victim

of sociological factors that went beyond her individual life. In addition to coming of age during the crack epidemic, the girlfriend had been abused as a child, and much of this abuse had to do with the fact that she “looked gay.” As a teenager, in order to deal with her emotional pain, she started self-medicating with alcohol and street drugs.

The author asked J.B. a series of Socratic questions, until J.B. was able to consciously state that she was not personally responsible for her girlfriend’s addiction or suicide. J.B. also described her girlfriend as a good person whose character had been impaired by her emotional difficulties and her addiction. J.B. told the author, “My mother really didn’t know who she was. She just saw her bad side, but her bad behavior was mostly related to cocaine.”

Further Socratic questioning revealed that J.B.’s daughter had forgiven J.B. for what had occurred. J.B. was unable to answer why she had not forgiven herself.

Because J.B. considered herself a Christian, and the one-on-one counseling was associated with a faith-based setting, J.B. and the author were able to explore some of the spiritual dimensions of this situation. Primarily (in terms of spirituality), the discussion included the concepts of forgiveness and self-forgiveness. J.B. also spoke of how she had tried to create some personal meaning out of this tragedy. In particular, since the event she had always tried “to make the world a better place,” especially for people like her girlfriend who had suffered so much. “I try to help black youth whenever I can,” said J.B. “Especially those who are gay. I try to listen to what they’re going through, and if I can, offer support.”

Besides Socratic questioning, the author used other CBT techniques with J.B. She asked J.B. if there were ways in which she could cognitively reframe what had occurred. J.B. was able to cognitively reframe some of the things that had happened, but both she and the author agreed that doing this would not be easy, and would require time and practice.

J.B. and the author also discussed ways that J.B. could more formally help gay youth of color. J.B. was familiar with the organization Gay, Lesbian, and Straight Educational Network (GLSN). She openly considered volunteering for GLSN, especially in assisting black gay youth. J.B. admitted that doing volunteer work in the past had helped increase her social networks and make her feel better about herself, while at the same time helping others.

As a final intervention, the author gave J.B. a list of local mental health practitioners that practiced on a sliding scale. She encouraged J.B. to call these people if J.B. felt she needed professional help.

J.B. verbalized that she felt that the session was very useful. In comparing peer counseling with formal therapy, J.B. felt that the peer session was “much more personal. I felt like we were speaking on the same level, and I wasn’t with a professional who was there just because they were getting paid to do this work.”

J.B. particularly found the discussions around the political, social, and historical aspects of this loss helpful. In addition, she found comfort in sharing spiritual reflections and insights with the author.

Finally, J.B. felt the session gave her an opportunity to get to know the author more and to support the author in her own history of loss. J.B. found that using her own experiences to help another individual was personally rewarding.

The author also found the sessions beneficial. While working as a psychiatric nurse, she had many times done one-on-one counseling with clients in a professional setting. However, she found the peer counseling unique to professional counseling, in that the author was able to more openly self-disclose, and also bring up topics regarding politics and spirituality.

Although it is certain that J.B. will continue to suffer many of the psychological ramifications of this tragic event, she clearly found the session of value. The session also helped further integrate J.B. into the connection she felt with the parish – which she verbalized as a major source of support.

*Summary of emerging themes.* In summation, the themes revealed in this interaction include:

- The effectiveness of peer counseling and CBT techniques.
- How service to others can help people heal from loss.
- The value of exploring the political, social, and historical perspectives of loss.
- The freedom of incorporating spirituality into one-on-one sessions in a faith-based setting.
- Sharing common experiences and finding comfort in recognizing the universality of loss.

**Rituals.** The themes that emerged in the focus group discussions can be summarized as such:

- Each Day of Remembrance was a major success. Many participants approached ministry members, thanking them for the rituals, and saying how much the events helped the client’s process their grief. The clients especially liked the music, the readings, and the opportunity for fellowship following the rituals.
- The ministry was able to attract more clients and volunteers as a result of the rituals.
- There were some logistic problems that came up during the planning and implementation of the ceremonies. The leader especially learned that she needed to “pin people down” to respective tasks. In other words, if someone volunteered to do something, they needed to

verbalize clearly what they were specifically volunteering to do. At times, it was assumed that someone would take responsibility for a job, but because their responsibility was not clearly communicated, some of the tasks “fell through the cracks.”

- The leader felt that at times people did not answer emails in an expedient manner. A request was made for emails to be promptly answered.
- In both of these events, there were serious problems with advertising. At least one individual “dropped the ball” in listing the event where it would reach a wider audience. Serious improvements were needed in advertising future events.

**Keating event.** Of 43 people who attended the event, 34 filled out surveys.

***Quantitative results.*** The quantitative results are listed below. The Likert scale survey spanned from zero to seven (zero being highly disagree and seven being highly agree).

Responses were tallied and a mean score was assigned to each question. The results revealed that a significant number of participants found the event highly satisfactory:

- Question 1: I learned a lot from today’s program: 6.06
- Question 2: The time and day of today’s program made it convenient for me to attend: 6.44
- Question 3: The speaker/s for today’s program was easy to understand: 6.41
- Question 4: The speaker/s for today’s program was engaging: 6.56
- Question 5. The audio/visual materials for today’s program were to my satisfaction: 6.59

***Qualitative results.*** The emerging themes from the qualitative questions are summarized below.

*Question one.* What about today’s program was especially helpful?

- Handouts



- Q & A sessions which included personal sharing
- Demonstration on meditation techniques

*Question two:* What about today's program could be improved?

- First DVD was too elementary
- No need for second meditation session
- Too much talk. Would have preferred to skip a lot of discussion and see more of the DVDs.

### **Structured group.**

***Quantitative results.*** As illustrated in Table 8 – the mean score for the pre-test was 2.533, and the post-test 3.017. The p-value for the difference between these scores is 0.0802, and using a 0.05 level of significance, the results of this analysis are not statistically significant by conventional standards. Nevertheless, there was some improvement in the post-test scores.

***Qualitative results.*** Four clients and both of the group leaders answered the qualitative questions. Their answers are presented in Table 9. The determined emerging themes from these responses are summarized below.

#### *Emerging themes from client responses.*

- The value of having an LGBT friendly group and members of similar backgrounds.
- The need to assess members for any sensory issues (such as hearing or visual problems).
- Suggestion to use name tags, especially during early sessions.
- The need to have more than six sessions.

#### *Emerging themes from co-leader responses.*

- The importance of using silence in therapeutic interactions.
- The value of screening clients prior to acceptance into a group.

- The benefits of a good relationship between co-leaders.

### **Discussion**

#### **Summary**

A parish needs assessment at MHR indicated that a sizable population of the MHR parishioners was interested in grief support. Most preferred educational venues and rituals, and of those who voiced an interest in grief groups, most preferred a structured to a drop-in format. A parish demographic survey conducted in 2012 helped determine the congregation's CG risk. Since a large segment of the parish is LGBT and over 60, the parishioners fit into high CG risk categories.

In response to the needs assessment, the G&C Ministry initiated several grief interventions. These included grief rituals, educational venues, and grief groups. Through these interventions the ministry gained visibility in the church, and people began approaching the ministry for peer one-on-one counseling. Increasingly, the parish office has also been referring parishioners to this service.

An evidence based manual on designing and implementing faith-based grief programs (Mortell, 2014) provided a framework for the MHR program and its training of volunteers. The rituals and educational venues became a platform for the ministry to connect with clients and recruit more volunteers. In addition, the ministry has started receiving referrals from an outside mental health agency.

Most of the clients served by these interventions were LGBT and over 60. As noted by the 2012 demographic survey (Table 1), this population is well represented in the church, and it also appears to be a growing demographic throughout San Francisco (Fredriksen-Goldsen et al., 2013).

Most qualitative analyses of the G&C interventions were positive. There was especially appreciation for the LGBT friendly component of the program, as well as the peer support format and the way the program addressed the historical and sociological roots of DG.

The quantitative evaluation of the educational venue was significantly positive, and its qualitative portion provided insights into how to improve future events. There was improvement in the pre and post-test CBI scores for the participants of the structured group. Although the improvement was not statistically significant, the qualitative analysis of the intervention was overwhelmingly affirmative.

As chair of the G&C Ministry, the author was able to help the group recruit more volunteers after a drastic drop in volunteerism. She was also able to help build alliances and collaboration with other church ministries – something that seemed crucial if the G&C Ministry was going to survive.

### **Relation to Other Evidence**

Many of the G&C Ministry's experiences reflect what has been retrieved from the literature. The need for proper training and screening of volunteers was paramount, as was the ability to confer with licensed therapists. Corey et al. (2014) prepared the co-leaders of the structured group for the anxiety clients expressed just prior to the termination of the group. The leaders were thus able to adequately prepare clients for this termination.

It was difficult recruiting for the structured group within the parish itself, and all of the subjects for the structured group ended up being women. This may have correlated with evidence surrounding populations that seek out, or are in need of mental health interventions. It also underlined the need for outreach to the wider community. The church's financial solvency has historically proven a much-needed resource for populations outside of MHR, and this was

especially evident with the structured group. In the trainings, one-on-one sessions, groups, and rituals, all of the information collected from the literature and compiled in Mortell (2014) proved highly useful to the G&C volunteers.

The challenges that the ministry encountered in dealing with an all-volunteer staff were also discussed in the literature (Moran et al., 2013). These challenges will be outlined in the next section on barriers to implementation.

### **Barriers to Implementation/Initiation**

The main barrier encountered this project involved dealing with an all-volunteer staff. For a variety of reasons, there appeared to be limited commitment to the project from some volunteers. In addition, the numbers of volunteers for this work were limited. This seems to reflect a larger issue in the church, and perhaps in other faith-based institutions. Cyndy Zimmer is a long time parishioner, and the current chair of MHR's Reconnecting Ministry (a ministry that helps integrate new parishioners into the church). She also helps organize collaborative meetings between ministry chairs. By her observation, "Very few individuals are committing their time to the parish ministries, and those that do, seem to be burning-out in recent years" (personal communication, July 29, 2014).

The author has discussed this problem with other ministry chairs. A main solution appears to be more consolidation of ministry work. For example, MHR's Ministry to the Homebound and AIDS Ministry both have a peer-support component. It's possible that these groups could benefit from some of the same peer counseling trainings that have been implemented for the G&C Ministry. Collaboration between ministries has already occurred with some of the 2014 educational events. The Centering Prayer, the Educational, and the G&C Ministries all worked together to make these events a success.

Further research needs to be done on how to recruit volunteers, and the G&C Ministry has not completely formulated a plan on how to screen volunteers. Although Mortell (2014) offers some insight on how to screen peer counselors, the G&C Ministry does not yet have a format to evaluate whether volunteers are appropriate for this work. The Ministry has thus far been fortunate, in that all of its volunteers have had previous training and experience in different forms of counseling – but future volunteers will definitely need to be put through some type of evaluation before they are allowed to work with clients.

### **Interpretation**

There is an apparent need for grief support in the MHR parish, and in the surrounding community. The provision of that support through a peer volunteer program has thus far proved successful.

As has been illustrated, because of MHR's location in San Francisco's Castro District, the church remains a resource that has been of great value to the LGBT community. The prevalence of older LGBTs seeking bereavement assistance through this program has helped underline the grief support needs of this population. Learning how to serve this demographic has also helped the ministry better understand the bereavement needs of other disenfranchised groups.

The G&C Ministry, like other ministries at MHR, has encountered problems with recruiting and retaining volunteers. It's possible that more collaboration between ministries could alleviate this dilemma – and a paid leadership position at MHR might supplement the work that up to this date has been left only to volunteers. A paid position might be able to bring more focused effort to recruiting and training volunteers, collaborating ministries, and perhaps expanding the G&C Ministry to assist people with psychosocial needs that extend beyond grief.

### **Funding**

The G&C Ministry currently operates on an annual budget of \$1500 (Table 10). All of this money comes directly from the church and the ministry itself does not generate any revenue. This budget is adequately addressing the ministry's current requirements, however if the ministry is to expand, there will be need for more funding. This section will discuss why and how the G&C Ministry might expand, and how such an expansion could be financed.

In identifying and addressing the bereavement needs of the parishioners at MHR, older LGBTs at MHR have stood out as a population that may especially require grief support. Since the parish serves the larger community, a more thorough evaluation of this population and its financial implications would include the Castro neighborhood, and perhaps all of San Francisco.

In this section, the argument is made for the G&C Ministry to extend its services beyond the issue of grief. Such an extension is worthy of consideration, because as noted, grief has been correlated with other mental health problems. Unresolved grief can intersect with other psychosocial issues, and as will be demonstrated, the psychosocial needs of older LGBTs in San Francisco are now at an increasingly high level.

Despite San Francisco's welcoming atmosphere for LGBTs, there have been numerous unfortunate circumstances surrounding the city's influx of gay residents. With their massive immigration into the city, gays have been separated from their families of origin and the support that might come from these families. Many gays have also given up career opportunities in order to live in San Francisco. In addition, LGBTs frequently carry psychological scars that have resulted from living in homophobic regions, families, or society in general (Pittman & Nolan, 2014).

The AIDS epidemic of the 1980s and 1990s was devastating to the gay community in terms of loss, and at this time, San Francisco is experiencing a major housing crisis. Due to San Francisco's burgeoning housing costs, many older gays are facing the loss of long time residences (Pittman & Nolan, 2014).

The (previous) inability to marry and establish socially accepted families might have also negatively impacted gays as they age. Although LGBTs typically create alternative families, according to the United States Department of Labor (2013), most unpaid caregiving of elders (61% of all caregiving of this group) is being done by a senior's child or grandchild. Even though these statistics typically refer to physical care, they indicate that children and grandchildren may be some of the main psychosocial support systems for seniors. Since gays tend to have fewer children than heterosexuals, older gays are less inclined to have this important source of support (Pittman & Nolan, 2014).

These conclusions are further substantiated by the following research involving LGBT seniors in San Francisco:

It is estimated that at least 12.4% of seniors over 60 in San Francisco identify as LGBT. Compared to other seniors, older LGBTs tend to suffer more from mental health issues, and have decreased access to mental health care. Older gays are also more likely to live in poverty, less inclined to be partnered or have children, and more likely to be living with HIV and to have experienced the death of a spouse (San Francisco LGBT Aging Policy Task Force [SF LGBT APTF], 2014).

In a recent study, 41% of participating San Francisco LGBT elders (compared to 17% of older people in the general population) said that they had seriously considered at some point

taking their own life. The LGBT elders also reported significantly high rates of depression, anxiety, loneliness, and stress (Fredriksen-Goldsen et al., 2013).

Despite this data, there appears to be a dearth of mental health resources for gays in San Francisco. Even when resources are available, gays may be reluctant to use these services due to real or perceived bias on the part of caregivers (SF LGBT APTF, 2014).

Nancy Heilner, LCSW is the Executive Director of Queer Life Space (QLS), one of the few mental health clinics in San Francisco that primarily treat LGBT clients. Although QLS is a nonprofit organization and offers therapy on a sliding scale, Heilner notes that the clinic does not accept MediCal, Medicare, or city funding. She claims that one problem with these providers is the restrictions they place on how often or how long clients can receive therapy. These restrictions conflict with the agency's belief that all clients should have the option to access long term support (personal communication, August 2, 2014).

It is unclear whether QLS's policies are similar to other San Francisco mental health providers; however, there is increasing evidence that people throughout the US are having trouble accessing mental health care. In recent years, there have been deep cuts made to state mental health budgets; and although the proposed changes with the Affordable Care Act (ACA) promise more federal money for mental health, many believe that these funds will in no way make up for the decreases that have occurred on the state level (National Alliance on Mental Illness [NAMI], 2013; Lippman, 2011; Gionfriddo, 2013). In addition, although the ACA requires that insurers cover mental illness on equal par with other illnesses, only half of US psychiatrists accept insurance (Kennedy, 2013). Psychiatrists in particular are opting for private pay only clients, or cutting back in their acceptance of Medicare, Medicaid and private non-capitated insurance (Bishop, Press, Keyhani & Pincus, 2014).



Due to the lack of mental health resources, especially for older LGBTs, the SF LGBT APTF (2014) is calling for more volunteer peer support services in San Francisco. Thus, the implementation and potential expansion the G&C Ministry and its volunteer peer support efforts, seem especially timely.

Most Holy Redeemer has historically stood as a resource for the gay community in San Francisco, especially during the AIDS crisis. This relationship has been reciprocal, for according to Peter Toms, Chair of MHR's Aids Ministry, membership and donations to the church increased during the AIDS epidemic (personal communication, August 10, 2014).

Mark Corelli, the current Financial Chair of MHR, notes that the recent high point for church attendance and membership was 2010-2011. Since then, Corelli states:

We have seen a 15% decline in attendance and a drop of 11.7% in collections.

Evaluating our current outreach programs and ministries, and being open and developing new ministries to the new and evolving needs of the local community, would most definitely be a positive influence to not only attendance, but also church contributions (personal communication, July 25, 2014).

### **Envisioning the Project's Future: A Proposal for a Parish Nurse Position**

The author has devoted many hours to the G&C Ministry as part of her DNP studies. She has also utilized her DNP education to provide leadership and knowledge to the ministry that may not otherwise be available to church volunteers. Within this process, she has come to see how a paid parish nurse position might serve as a continuation of this work. A parish nurse could also consolidate other ministries into a service that could help meet the wider psychosocial needs of MHR, and the surrounding city. A prospective MHR parish nurse would ideally have a background in psychiatry, grant writing, and program development.

**Proposed parish nurse position at MHR.** A proposed parish nurse at MHR could potentially:

1. Help consolidate existing ministries' budgets and volunteers into a psychosocial peer support program. The program would welcome clients of all ages and demographic backgrounds, but it would be particularly sensitive to the needs of LGBT seniors.
2. Establish a system to train and recruit volunteers.
3. Collaborate with outside organizations to increase resources.
4. Write grants so that the nursing position could be sustained.

**Potential sources of funding for a parish nurse position.**

*Increased collaboration between MHR ministries.* Since some of the psychosocial ministries at MHR are providing overlapping services and trainings, combining these ministries could expand parish resources.

*Most Holy Redeemer training its own volunteers.* If the church could provide its own trainings, it could save money. Most Holy Redeemer could also offer these trainings (at a fee) to other local parishes and community organizations.

*Increased revenue as a result of outreach.* An increase in community psychosocial outreach to older gays could result in increased church membership and donations. Thus, such outreach could possibly be an indirect source of revenue for the church.

*Grant writing and collaboration.* Due to the recommendations of the SF LGBT APTF (2014), there may be more available grants for organizations that provide volunteer peer support to LGBT seniors. If MHR could pay a grant writer \$12,000, the writer could work comfortably through a full year on a contract basis. This would cover the cost of researching prospective funders, and writing the grants.

*Cost/benefit analysis of grant writer salary.* The \$12,000 fee could potentially be supplemented by donations and special events. If the grant writer secures funding, this money may ideally exceed the cost of a parish nurse and provide additional revenue for the church. Improved services resulting from the parish nurse position could increase both community services and church revenue.

**Collaboration.** Research indicates that faith-based funding can be increased through inter-organizational collaboration (Dossett , Fuentes, Klap & Wells, 2005; Hickman, 2011). This collaboration appears to work best when organizations use a time-limited approach to defined goals. Time-limited models work well with volunteer-driven organizations, as these models take less time and commitment than more formal partnerships (Hickman, 2011).

**Market analysis.** Gay people have unique psychosocial needs, and MHR has historically addressed these needs, not only for the parish, but also for the surrounding community. As the local LGBT population ages, these needs will continue to grow. Unfortunately, this growth coincides with a rapid decrease in available mental health services. Thus, free and low cost supportive mental health care that is provided by faith-based venues will remain in high demand.

**Explanation of the program and its implementation.** Once funding is obtained, a part-time registered nurse could be hired at a salary of \$30,000 per year. The pastor and the parish council could most likely screen applicants.

The nurse could consolidate and lead the church's existing psychosocial ministries. The nurse could also recruit peer volunteers from the church and surrounding community and provide their training. In addition, the nurse could help sustain the funding for the parish nurse program and build alliances with other faith-based and community resources in San Francisco.

A SWOT Analysis (Table 11) describes the strengths, weaknesses, opportunities and threats of this proposition. Table 12 presents a hypothetical budget and timeline.

### **Conclusion**

Jenny Girard-Malley, MA is the former Pastoral Associate at MHR and was one of the founding members of the G&C Ministry. The below statement by Girard-Malley perhaps best summarizes the benefits of MHR's grief program both to the parish and the community:

Having a partnership between a lay-led G&C Ministry and pastoral staff provides a wonderful blend of resources to those seeking help during a time of struggle. Parish staff is often stretched to capacity, and lay parishioners can be present as companions to those needing healing. I found my work with the G&C Ministry at the parish level to be extremely important. We were able to tap into the gifts and talents of our team so that our community had access to support that was responsive to their needs. I don't think parish staff could do adequate grief support without such a dedicated team of parish volunteers (personal communication, August 25, 2014).

Girard-Malley's comments emphasize the need of G&C Ministry and the assistance it has thus far provided to bereaving individuals. Future goals of this project may be to work more with other MHR ministries and help expand all of MHR's existing services. As has been illustrated, a parish nurse position at MHR could possibly be a vital ingredient in this program's expansion.

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## Tables and Appendices

### Tables

Table 1  
*Most Holy Redeemer 2012 Demographic Survey*

Item	Percent	N =
Female	27.78	20
Male	70.83	51
Heterosexual	44.4	32
LGBTQ	40.28	29
“Queer”	8.33	6
Prefer not to identify sexual orientation	5.56	4
17 or younger	0	0
18-20	2.78	2
21-29	4.17	3
30-39	18.06	13
40-49	18.06	13
50-59	13.89	10
60 or older	43.06	31



Table 2  
*Most Holy Redeemer 2013-2014 Parish Needs Assessment*

<b>I have an interest in participating in the following types of bereavement programs:</b>		
<b>Answer Options</b>	<b>Response Percent</b>	<b>Response Count</b>
Rituals	48.3%	14
Educational Programs	72.4%	21
Individual Peer Counseling	24.1%	7
A Grief Group	37.9%	11
<i>answered question</i>		<b>29</b>
<i>skipped question</i>		<b>11</b>
<b>If interested in a grief group, please specify type:</b>		
<b>Answer Options</b>	<b>Response Percent</b>	<b>Response Count</b>
Drop in group	38.5%	5
Structured group with 6-8 sessions	84.6%	11
<i>answered question</i>		<b>13</b>
<i>skipped question</i>		<b>27</b>

Table 3  
*Evidence Level and Quality Guide (Dearholt et al., 2012a)*

<p><b>Level I</b>                  Experimental study, randomized controlled trial (RTC)                  Systematic review of RTCs, with or without meta-analysis</p> <p><b>Level II</b>                  Quasi-experimental study                  Systematic review of a combination of RCT's and quasi-experimental or quasi-experimental only, with or without meta-analysis</p> <p><b>Level III</b>                  Non-experimental study                  Systematic review of a combination of RCT's, quasi-experimental and non-experimental studies, or non-experimental studies only, with or without meta-analysis                  Qualitative study or systematic review with or without a meta-synthesis</p>	<p>A. <b>High quality:</b> consistent, generalizable results: sufficient sample size for the study design: adequate control: definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence.</p> <p>B. <b>Good quality:</b> Reasonably consistent results; sufficient sample size for the study design; some control, fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific reference.</p> <p>C. <b>Low quality or major flaws:</b> Little evidence with inconsistent results; insufficient sample size for the study design, conclusions cannot be drawn.</p>
<p><b>Level IV</b>                  Opinion of respected authorities and/or nationally recognized expert committee/consensus panels based on scientific evidence</p> <p>Includes:</p> <ul style="list-style-type: none"> <li>• Clinical practice guidelines</li> <li>• Consensus panels</li> </ul>	<p>A. <b>High quality:</b> Material officially sponsored by a professional, public, private organization, or government agency: documentation of a systematic literature search strategy: consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific strength and quality of included studies and definitive conclusions; national expertise is clearly evident; developed or revised within the last 5 years.</p> <p>B. <b>Good quality:</b> Material officially sponsored by a professional, public, private organization or government agency; reasonably thorough and appropriate systematic literature search strategy; reasonably consistent results, sufficient numbers of well-designed studies; evaluation of strengths and limitations of included studies with fairly definitive</p>

	<p>conclusions; national expertise is clearly evident; developed or revised within the last 5 years.</p> <p>C. <b><u>Low quality or major flaws:</u></b> Material not sponsored by an official organization or agency; undefined, poorly defined, or limited literature search strategy; no evaluation of strengths and limitations of included studies, insufficient evidence with inconsistent results, conclusions cannot be drawn; not revised within the last 5 years.</p>
<p><b>Level V</b> Based on experiential and non-research evidence</p> <p>Includes:</p> <ul style="list-style-type: none"> <li>• Literature reviews</li> <li>• Quality improvement, program or financial evaluation.</li> <li>• Case reports</li> <li>• Opinion of nationally recognized expert(s) based on experiential evidence</li> </ul>	<p><b>Organizational Experience:</b></p> <p>A. <b><u>High quality:</u></b> Clear aims and objectives; consistent results across multiple settings; formal quality improvement, financial or program evaluation methods used; definitive conclusions; consistent recommendations with thorough reference to scientific evidence.</p> <p>B. <b><u>Good quality:</u></b> Clear aims and objectives; consistent results in a single setting; formal quality improvement or financial or program evaluation methods used; reasonably consistent recommendations with some reference to scientific evidence.</p> <p>C. <b><u>Low quality or major flaws:</u></b> Unclear or missing aims and objectives; poorly defined quality improvement, financial or program evaluation methods; recommendations cannot be made.</p> <p><b>Literature Review, Expert Opinion, Case Report, Community Standard, Clinician Experience, Consumer Preference:</b></p> <p>A. <b><u>High quality:</u></b> Expertise is clearly evident: draws definitive conclusions; provides scientific rationale; thought leader(s) in the field.</p> <p>B. <b><u>Good quality:</u></b> Expertise appears to be credible; draws fairly definitive conclusions; provides logical</p>

	<p>argument for opinions.</p> <p><b>C. <u>Low quality or major flaws:</u></b> Expertise is not discernable or is dubious; conclusions cannot be drawn</p>
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Table 4

*Non-Research Evidence Appraisal Tool (Dearholt et al., 2012b)*

**Does this evidence address the EBP question?**

If the answer is yes – proceed with the appraisal of evidence.

**Clinical practice guidelines:** Systematically developed recommendations from nationally recognized experts based on research evidence or expert consensus panel. **LEVEL IV**

**Consensus or Position Statement:** Systematically developed recommendations based on research and nationally recognized expert opinion that guides members of a professional organization in decision-making for an issue of concern. **LEVEL IV**

**Please answer Yes or No:**

- Are the types of evidence included identified?
- Were appropriate stakeholders involved in the development of recommendations?
- Are groups to which recommendations apply and do not apply clearly stated?
- Have potential biases been eliminated?
- Were recommendations valid (reproducible search, expert consensus, independent review, current and level of supporting evidence identified for each recommendation)?
- Were the recommendations supported by the evidence?
- Are recommendations clear?

**Literature Review:** Summary of published literature without systematic appraisal of evidence quality or strength. **LEVEL V**

**Please answer Yes or No:**

- Is subject matter to be reviewed clearly stated?
- Is relevant, up-to-date literature included in the review (most sources within last 5 years or classic)?
- Is there a meaningful analysis of the conclusions of the literature?
- Are gaps in the literature identified?
- Are recommendations made for future practice or study?

**Expert Opinion:** Opinion of one or more individuals based on clinical expertise. **LEVEL V**

**Please answer Yes or No:**

- Has the individual published or presented on the topic?
- Is the author's opinion based on scientific evidence?
- Is the author's opinion clearly stated?
- Are potential biases acknowledged?

**STRENGTH OF EVIDENCE****LEVEL 4****SYSTEMATIC REVIEW**

- Research review that complies and summarize evidence from research studies related to a specific clinical question
- Employs comprehensive search strategies and rigorous appraisal methods
- Contains an evaluation of strengths and limitations of studies under review

**CLINICAL PRACTICE GUIDELINES**

- Research and experiential evidence review that systematically develops statements that are meant to guide decision-making for specific clinical circumstances
- Evidence is appraised and synthesized from three basic sources: scientific findings, clinician expertise, and patient preferences

**LEVEL 5****ORGANIZATIONAL**

- Review of quality improvement studies and financial analysis reports
- Evidence is appraised and synthesized from two basic sources: internal reports and external published reports

**EXPERT OPINION, CASE STUDY, LITERATURE REVIEW**

- Opinion of nationally recognized expert based on non-research evidence (includes case studies, literature review, or personal experience).

**QUALITY RATING (SUMMATIVE REVIEWS)**

- A. High quality: well-defined, reproducible search strategies; consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific strength and quality of included studies, and definitive conclusions
- B. Good quality: reasonably thorough and appropriate search; reasonably consistent results, sufficient numbers of well-designed studies, evaluation of strengths and limitations of included studies, with fairly definitive results.
- C. Low quality or major flaws: undefined, poorly defined, or limited search strategies; insufficient evidence with inconsistent results, conclusions cannot be drawn

**QUALITY RATING (EXPERT OPINION)**

- A. High quality: expert is clearly evident.
- B. Good quality: expertise appears to be credible
- C. Low quality or major flaws: expertise is not discernable or is dubious

Table 5

*Domain One Appraisal of Review based on Dearholt et al. (2012a; 2012b)*

Study	Limitations	Level of evidence	Worth to Practice
Barlow et al., 2010	The criterion sampling used limited representation in regards to gender, ethnicity, age (only three participants were men). Since the program relied on emerging sampling, and because participants were proponents of program, the results may be biased. In addition, the study only captured losses particular to the available situations. Some losses, such as those of a mother, father or daughter, were not included.	<p style="text-align: center;"><b>II B</b></p> Quasi-experimental study Systematic review of a combination of RCTs and quasi-experimental or quasi-experimental only, without meta-analysis  Reasonably consistent results; sufficient sample size for the study design; some control, fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific reference.	A peer support program around suicide loss may be helpful to both volunteers and clients. Some concerns that arose (such as establishing proper boundaries, and unsuccessful matches between dyads, and an inability of some volunteers to elicit client response), might be addressed with increased consultation by a mental health professional. Also, matching clients with similar losses and bringing up family issues following loss may be useful.  The HGRC may be an appropriate instrument for program evaluation as well as the suggested qualitative questions.
Dossett et al. (2005)	Reliance on self-measures. Survey was done on only one faith-based network, so the results may not	<p style="text-align: center;"><b>II B</b></p> Quasi-experimental study Systematic review of a combination of	Underlines the need for mental health services within a faith community and the main barriers

	<p>be generalizable. Limited data provided on the particular mental health services used</p>	<p>RCTs and quasi-experimental or quasi-experimental only, without meta-analysis</p> <p>Despite data limited to specific population and reliance on self-measures, reasonably consistent results and sample size with fairly consistent conclusions.</p>	<p>(funding, training and personnel) in providing these services. Possible that networking and forming partnerships with other professional organization may help alleviate deficits in future programs. The lack of support from congregants is worthy of consideration.</p> <p>Appears to be a need for mental health services within faith-based communities, but perhaps need for more outreach and education to community members so that they can recognize these needs and find ways to access services.</p>
<p>Fajgenbaum, et al. (2012)</p>	<p>Student leaders may at times be ill-equipped to handle some grief situations. Risk that volunteer leaders may lead groups in a harmful way.</p> <p>Although there are hundreds of testimonials regarding AMF effectiveness, the program has not undergone any quantitative or</p>	<p><b>V C</b></p> <p>Based on experiential and non-research evidence. Includes case reports and opinion of nationally recognized experts based on experiential evidence</p> <p>Little evidence with some consistent results. Insufficient sample size. Some conclusions may be drawn.</p>	<p>Underlines the usefulness of peer support groups, especially when group leaders have specialized training and back-up support from professional mental health advisers and outside referrals.</p> <p>The idea of a service program seems especially innovative in a faith-based setting – a setting</p>



	<p>qualitative analysis.</p>		<p>which already has many opportunities for service. If grieving individuals can be guided to take part in service, this may provide an important component to their healing process.</p>
<p>Ho (2007)</p>	<p>Sample recruited from one district in Hong Kong, thus, study may not be generalizable. Sample was small (30), and has limited statistical power, restricting restricts further data analysis. Sample not randomized and the single-group pre and post tests (no control) limited the study's generalizability.</p> <p>Quantitative results were significant, but the positive outcomes could have been associated with the referrals to higher levels of care. `</p> <p>Focus group interviews on volunteers were restricted by lack of triangulation and other qualitative methods (such as participant observation or by interviewing trainers).</p>	<p><b>III B</b> Non-experimental study with qualitative component</p> <p>Reasonably consistent results; sufficient sample size for the study design; some control, fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific reference.</p>	<p>Intervention appeared beneficial to both counselors and clients. Study indicates that trained peer counselors may be a good source of supplementary care for home-bound elderly, and as a means of assisting referring clients to higher levels of care.</p> <p>Program serves as a model for providing peer support to home-bound elderly who suffer from depression. Feedback from the counselors indicates that helping people with depression is challenging, and requires specialized training.</p> <p>The numbers of elderly who ended up needing higher levels of care also underlines the need to train counselors in assessment and</p>

			referrals.
Kotecki (2002)	<p>Little uniformity in some survey questions which made them difficult to evaluate</p> <p>Funding was a major problem in sustaining project.</p>	<p><b>III B</b></p> <p>Quasi-experimental study without meta-analysis</p> <p>Some control with sufficient sample size. Reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific reference.</p> <p>Qualitative component presented further insights into benefits of intervention</p>	<p>The FBHTP serves as a model for an educational intervention within a faith-based setting.</p> <p>Underlines the use of both faculty and students within a school of nursing as a potential resource.</p>
Pickett-Schenk (2002)	<p>Sample size was small, and no pre and post-tests. Study relied only on self-reports, and focus on an African American congregation may not make the results generalizable.</p>	<p><b>III B</b></p> <p>Non-experimental study without meta-analysis. Qualitative component without meta-synthesis.</p> <p>Some consistent results, inefficient sample size. Conclusions can be drawn with reference to scientific evidence.</p>	<p>Illustrates benefits of providing community mental health care within a cultural context in a faith-based setting. Peer support (with professional back-up), and the role of the church as a coping resource is recognized.</p> <p>Transportation, childcare, and having meetings in familiar settings with food and music were helpful.</p>
Spencer et al. (2013)	<p>PAID and PHQ instruments may not relate directly to</p>	<p><b>IIB</b></p> <p>Quasi-experimental, RCT.</p>	<p>Study suggests that a CHW intervention, which included</p>

	<p>other mental health outcomes such as anxiety. Members of the delayed group expressed frustration with randomization process, and having to wait for services. Experiences of the CHWs were not assessed.</p>	<p>Reasonably consistent results with sufficient sample size. Fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that contains reference to scientific evidence.</p>	<p>increased social support and education, may significantly decrease mental health conditions in diabetic clients. This could have potentially reduced barriers to diabetic self-management.</p> <p>Study underlines effectiveness of peer support in educating clients, and assisting them in developing treatment goals and strategies.</p> <p>Study uses empowerment theory, a collaborative approach, which helps clients take a proactive part in their health management goals. It also addresses the value of accompanying clients to medical appointments. In addition, it suggests the importance of coupling volunteers with clients of similar demographic backgrounds.</p>
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Table 6

*Domain Two Appraisal of Review based on Dearholt et al. (2012a)*

Study	Limitations	Level of evidence	Worth to Practice
Cacciatore (2007)	Low sample size impinges on generalizability. Purposive, rather than random sampling. Self-administered survey (prone to inaccuracies). No clarification of precise nature of support groups.	<ul style="list-style-type: none"> <li>• <b>III B</b></li> </ul> Non-experimental study only. Contained qualitative analysis without meta-synthesis. Reasonably consistent results; sufficient sample size for study design; some control, fairly definitive conclusions, reasonably consistent recommendations based on fairly comprehensive literature review with reference to scientific evidence.	Underlined value of using groups to treat grief. Feedback from women gave specific information on what works best in groups.
Eagle et al. (2012)	Sample non-randomized and small. Qualitative component may have given further insights into results of intervention. Study done on medical professionals, so results may not be generalizable.	<ul style="list-style-type: none"> <li>• <b>III C</b></li> </ul> Quasi-experimental study. Inconsistent results. Small, but sufficient sample size, and some control. Recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence.	Evidence that support received from group may have increased personal growth of participants.

		Substantial, but not significant results.	
Goodman & Stone (2009)	Non-randomization and little control over group's leadership, protocol or membership. One screening tool (RCOPE) was in early developmental stages so results of test may not be generalizable.	<ul style="list-style-type: none"> <li>• <b>III B</b></li> </ul> Quasi-experimental. Convenience sample Sufficient sample size. Recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence.	Insights into positive vs. negative use of religion/spirituality in dealing with grief.
Olson & McEwen (2004)	Qualitative study where results were evaluated by intervention facilitators.	<ul style="list-style-type: none"> <li>• <b>III B</b></li> </ul> Qualitative study. Reasonably consistent results, sufficient sample size, some control, with fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence.	Study presented theoretical framework in which group support could be structured. Many helpful insights into what helped and what did not help the bereaved.
Steiner (2006)	Small, qualitative, exploratory study. Study was conducted by a facilitator of one of the group interventions.	<ul style="list-style-type: none"> <li>• <b>III B</b></li> </ul> Qualitative study. Reasonably consistent results, sufficient sample size, some control, with fairly definitive	Offered insights into what does and what does not help the bereaved. Provided insights into the need for bereavement groups and ways to increase participation and access.

		conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence.	
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Table 7

*Domain Three Appraisal of Review based on Dearholt et al. (2012b)*

**Beattie, Shaw, Kaur & Kessler (2009)**

**Level III B**

Qualitative study

Limited in that it used only online CBT and most participants were female. Study did underline the CBT benefits of writing.

**Quality rating:**

Reasonably consistent results; sufficient sample size for the study design; some control, fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence.

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**Brooks-Harris, 2001**

**Level V B**

Expert Opinion

**Strength of evidence**

Author has individually published on the topic

Author's opinion is based on scientific evidence

Author's opinion is clearly stated

Potential biases are acknowledged

Opinion of nationally recognized expert based on non-research evidence (case study)

**Quality rating:**

B: Expertise appears credible

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**Calvert & Palmer, 2003**

**Level IV B**

Clinical practice guidelines

**Strength of evidence**

Systematically developed recommendations from nationally recognized experts based on research evidence

Research and experiential evidence review systematically develops statements that are meant to guide decision-making for specific clinical circumstances

Evidence is appraised and synthesized from scientific findings, clinician expertise, and patient preferences.

Types of evidence are included and identified

Groups to which recommendations apply and do not apply are clearly stated

Potential biases have been eliminated

Recommendations are valid according to identified supporting evidence

Recommendations are supported by the evidence

Recommendations are clear

**Quality rating:**

B: Reasonably thorough and appropriate search; reasonably consistent results, sufficient numbers of well-designed studies, evaluation of strengths and limitations of included studies, with fairly definitive results.

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**Corey, Corey & Corey (2014)****Level IV A**

Clinical practice guidelines

**Strength of Evidence**

Systematically developed recommendations from nationally recognized experts based on research evidence

Research and experiential evidence review systematically develops statements that are meant to guide decision-making for specific clinical circumstances

Evidence is appraised and synthesized from scientific findings, clinician expertise, and patient preferences.

Types of evidence are included and identified

Groups to which recommendations apply and do not apply are clearly stated

Potential biases have been eliminated

Recommendations are valid according to identified supporting evidence

Recommendations are supported by the evidence

Recommendations are clear

**Quality rating:**

A: Well-defined reproducible search strategies; consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific strength and quality of included studies and definitive conclusions

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**Currier, Holland & Neimeyer (2010)****Level I B**

Systematic review of RTCs without meta-analysis

**Strength of evidence:**

Authors noted some deficiencies in study controls. Strong evidence that CBT can help the bereaved. Recommendation that CBT works best when supplemented with other therapies.

**Quality rating:**

Reasonably consistent results; sufficient sample size for the study design; some control, fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes reference to scientific evidence.

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**Doka & Aber (2002)****Level V B**

Expert Opinion

**Strength of Evidence**

Author has individually published on the topic



Author's opinion is based on scientific evidence  
Author's opinion is clearly stated  
Potential biases are acknowledged  
Opinion of nationally recognized expert based on research evidence.

**Quality rating:**

B: Expertise appears credible

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**Doka (2002)**

**Level V B**

Expert Opinion

**Strength of Evidence**

Author has individually published on the topic  
Author's opinion is based on scientific evidence  
Author's opinion is clearly stated  
Potential biases are acknowledged  
Opinion of nationally recognized expert based on research evidence.

**Quality rating:**

B: Expertise appears credible

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**Duran, Firehammer & Gonzalez (2008).**

**Level IV B**

Clinical practice guidelines

**Strength of Evidence:**

Systematically developed recommendations from nationally recognized experts based on research evidence  
Research and experiential evidence review systematically develops statements that are meant to guide decision-making for specific clinical circumstances  
Evidence is appraised and synthesized from scientific findings, clinician expertise, and patient preferences.

Types of evidence are included and identified

Groups to which recommendations apply and do not apply are clearly stated

Potential biases have been eliminated

Recommendations are valid according to identified supporting evidence

Recommendations are supported by the evidence

Recommendations are clear

**Quality rating:**

B: Reasonably thorough and appropriate search; reasonably consistent results, sufficient numbers of well-designed studies, evaluation of strengths and limitations of included studies, with fairly definitive results.

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**Humphrey (2009)**

**Level IV A**

Clinical practice guidelines

**Strength of Evidence**

Systematically developed recommendations from nationally recognized experts based on research evidence

Research and experiential evidence review systematically develops statements that are meant to guide decision-making for specific clinical circumstances

Evidence is appraised and synthesized from scientific findings, clinician expertise, and patient preferences.

Types of evidence are included and identified

Groups to which recommendations apply and do not apply are clearly stated

Potential biases have been eliminated

Recommendations are valid according to identified supporting evidence

Recommendations are supported by the evidence

Recommendations are clear

**Quality rating:**

A: Well-defined reproducible search strategies; consistent results with sufficient numbers of well-designed studies;; criteria-based evaluation of overall scientific strength and quality of included studies and definitive conclusions.

**McNutt & Yakushko (2013)****Level V B**

Literature Review with case studies

**Strength of Evidence**

Subject matter reviewed is clearly stated

Relevant, up-to-date sources are used (most within 5 years or classic).

A meaningful analysis is made of the conclusions

Gaps in the literature are identified

Recommendations are made for future practice and study

Quality rating:

A. Reasonably thorough and appropriate search; reasonably consistent results, sufficient numbers of well-designed studies, evaluation of strengths and limitations of included studies with fairly definitive results

**Olson & McEwen (2004).****Level III B**

See Table 6

**Strength of Evidence**

Non-experimental qualitative study

**Quality Rating:**

Reasonably consistent results; sufficient sample size for the study design; some control, fairly definitive conclusions, reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence.

**Neimeyer (2012)****Level IV B**

Clinical practice guidelines

**Strength of evidence**

Systematically developed recommendations from nationally recognized experts based on research evidence

Research and experiential evidence review systematically develops statements that are meant to guide decision-making for specific clinical circumstances

Evidence is appraised and synthesized from scientific findings, clinician expertise, and patient preferences.

Types of evidence are included and identified

Groups to which recommendations apply and do not apply are clearly stated

Potential biases have been eliminated

Recommendations are valid according to identified supporting evidence

Recommendations are supported by the evidence

Recommendations are clear

**Quality rating:**

B: Reasonably thorough and appropriate search; reasonably consistent results, sufficient numbers of well-designed studies, evaluation of strengths and limitations of included studies, with fairly definitive results.

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**Neimeyer & Jordan (2002)****Level IV B**

Clinical practice guidelines

**Strength of Evidence:**

Systematically developed recommendations from nationally recognized experts based on research evidence

Research and experiential evidence review systematically develops statements that are meant to guide decision-making for specific clinical circumstances

Evidence is appraised and synthesized from scientific findings, clinician expertise, and patient preferences.

Types of evidence are included and identified

Groups to which recommendations apply and do not apply are clearly stated

Potential biases have been eliminated

Recommendations are valid according to identified supporting evidence

Recommendations are supported by the evidence

Recommendations are clear

**Quality rating:**

B: Reasonably thorough and appropriate search; reasonably consistent results, sufficient numbers of well-designed studies, evaluation of strengths and limitations of included studies, with fairly definitive results.

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**Overholser (2013)****Level IV B**

Clinical practice guidelines

**Strength of Evidence**

Systematically developed recommendations from nationally recognized experts based on research evidence

Research and experiential evidence review systematically develops statements that are meant to guide decision-making for specific clinical circumstances

Evidence is appraised and synthesized from scientific findings, clinician expertise, and patient preferences.

Types of evidence are included and identified

Groups to which recommendations apply and do not apply are clearly stated

Potential biases have been eliminated

Recommendations are valid according to identified supporting evidence

Recommendations are supported by the evidence

Recommendations are clear

**Quality rating:**

B: Reasonably thorough and appropriate search; reasonably consistent results, sufficient numbers of well-designed studies, evaluation of strengths and limitations of included studies, with fairly definitive results.

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**Piper, Ogrodniczuk, Joyce & Weideman (2011)****Level IV A**

Clinical practice guidelines

**Strength of Evidence**

Systematically developed recommendations from nationally recognized experts based on research evidence

Research and experiential evidence review systematically develops statements that are meant to guide decision-making for specific clinical circumstances

Evidence is appraised and synthesized from scientific findings, clinician expertise, and patient preferences.

Types of evidence are included and identified

Groups to which recommendations apply and do not apply are clearly stated

Potential biases have been eliminated

Recommendations are valid according to identified supporting evidence

Recommendations are supported by the evidence

Recommendations are clear

**Quality rating:**

A: Well-defined reproducible search strategies; consistent results with sufficient numbers of well-designed studies, criteria-based evaluation of overall scientific strength and quality of included studies and definitive conclusions.

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**Reimers (2011)****Level V B**

Literature review

**Strength of evidence:**

Subject matter is clearly stated

Relevant, up-to-date literature is included in review – however most more than 5 years old

Gaps in literature are identified

Recommendations made for future practice and study

**Quality rating:**

Reasonably thorough and appropriate search; reasonably consistent results, sufficient number of well-designed studies, evaluation of strengths and limitations of included studies, with fairly definitive results.

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**Reynolds (2002)****Level IV A**

Clinical practice guidelines

**Strength of Evidence**

Systematically developed recommendations from nationally recognized experts based on research evidence

Research and experiential evidence review systematically develops statements that are meant to guide decision-making for specific clinical circumstances

Evidence is appraised and synthesized from scientific findings, clinician expertise, and patient preferences.

Types of evidence are included and identified

Groups to which recommendations apply and do not apply are clearly stated

Potential biases have been eliminated

Recommendations are valid according to identified supporting evidence

Recommendations are supported by the evidence

Recommendations are clear

**Quality rating:**

A: Well-defined reproducible search strategies; consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific strength and quality of included studies and definitive conclusions

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**Washington State's Division of Behavioral Health & Recovery (2009)****Level IV C**

Clinical practice guidelines

**Strength of evidence:**

Systematically developed recommendations from nationally recognized experts. No indication of potential bias elimination, no supporting evidence listed. Recommendations are clear. Groups which recommendation apply are clearly stated.

Quality rating:

C: Expertise is dubious.

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**Todd (2011)****Level V B**

Literature review

**Strength of evidence:**

Subject matter is clearly stated

Relevant, up-to-date literature is included in review – however most more than 5 years old

Gaps in literature are identified

Recommendations made for future practice and study

**Quality rating:**

Reasonably thorough and appropriate search; reasonably consistent results, sufficient number of well-designed studies, evaluation of strengths and limitations of included studies, with fairly definitive results.

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**Wezel, Brown & Karlin (2011)****Level IV A**

Clinical practice guidelines with case studies

**Strength of evidence:**

Systematically developed recommendations from nationally recognized experts based on research evidence

Research and experiential evidence review systematically develops statements that are meant to guide decision-making for specific clinical circumstances

Evidence is appraised and synthesized from scientific findings, clinician expertise, and patient preferences.

Types of evidence are included and identified

Groups to which recommendations apply and do not apply are clearly stated

Potential biases have been eliminated

Recommendations are valid according to identified supporting evidence

Recommendations are supported by the evidence

Recommendations are clear

**Quality rating:**

Expertise is clearly evident

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**Yalom & Leszcz (2005)****Level IV A**

Clinical practice guidelines

**Strength of Evidence**

Systematically developed recommendations from nationally recognized experts based on research evidence

Research and experiential evidence review systematically develops statements that are meant to guide decision-making for specific clinical circumstances

Evidence is appraised and synthesized from scientific findings, clinician expertise, and patient preferences.

Types of evidence are included and identified

Groups to which recommendations apply and do not apply are clearly stated

Potential biases have been eliminated

Recommendations are valid according to identified supporting evidence

Recommendations are supported by the evidence

Recommendations are clear

**Quality rating:**

A: Well-defined reproducible search strategies; consistent results with sufficient numbers of well-designed studies;; criteria-based evaluation of overall scientific strength and quality of included studies and definitive conclusions

Table 8  
*Grief Group Analysis of Core Bereavement Index Scores*

Pre-test	Post-test	
2.9	3.4	
2.6	3.2	
2.5	3.4	
3.5	3.2	
2.3	3	
1.4	1.9	
<b>P value and statistical significance:</b> The two-tailed P value equals 0.0802		
The mean of Group One minus Group Two equals -0.484. 95% confidence interval of this difference: From -1.052 to 0.092		
<b>Confidence interval: Intermediate values used in calculations:</b> t = 2.3311 df = 4 standard error of difference = 0.206		
	<b>Group One</b>	<b>Group Two</b>
<b>Mean</b>	<b>2.533</b>	<b>3.017</b>
<b>SD</b>	<b>0.695</b>	<b>0.167</b>
<b>SEM</b>	<b>0.284</b>	<b>0.075</b>



Table 9  
*Qualitative Results from Grief Group*

<b>Respondent</b>	<b>Question One: What did you find helpful in this group?</b>	<b>Question Two: What elements in this group could be improved?</b>
<b>Co-leader 1 (author)</b>	I felt I had a very good rapport with the co-leader and we functioned well as a team. I think much of this had to do with the fact that we were good friends and had known each other for years. The stringent screening process paid off. All clients fit into inclusion criteria and were appropriate for the group.	I learned how much I don't know about leading a grief group. Without a therapist present, I could have never helped clients in this much emotional distress. It made me realize that serious training and screening is needed of leaders and clients need to be informed clearly that peer support is not therapy. Also, outside referrals need to be available.
<b>Co-leader 2 (therapist)</b>	Excellent choice of group members. My co-leader did a very good job with screening. We also worked well together as co-leaders and I saw growth as the weeks went along in my partner's ability to therapeutically communicate with clients.	I would encourage my co-leader to become more comfortable with periods of silence during sessions. Silence can be a very important part of group work.
<b>Client 1</b>	The leaders created a very supportive, comfortable, and accepting environment. Each member had a chance to speak. No one dominated the group. One leader's willingness to bring examples and observations from he own life humanized the leaders and made expressing personal feelings and experiences easier and more valued. The other leader's beginning meditation and ending summaries book ended each session. The final observations from the leaders gave me something to focus on from what I had brought to the session. Salient points were brought to light. The care and concern of both facilitators were evident.	Occasionally one of the members did run on for a longer time than I felt was useful. I think that, although a bit awkward, name tags might have been useful through the 2nd session, so I could fix everyone's name in my mind. I had some difficulty hearing one or two of the other members. My hearing, the acoustics, and the tendency to talk in a very soft voice all contributed.
<b>Client 2</b>	I liked the fact that the group was gay friendly. That way I felt safer in	I wish that the group had gone on longer. I felt it ended too soon in only

	sharing what I was going through. I thought the leaders were very helpful and it helped me to see what the other women were going through.	six weeks.
<b>Client 3</b>	The leaders seemed to really care and I liked that there were all women in the group and mostly lesbian. The homework assignments were very helpful.	I wished we could have shared more of the writing assignments with each other. I wish the group had gone on longer.
<b>Client 4</b>	I have thought about the grief group a lot and benefitted from it. I think it was a special experience as well as a privilege to participate and also help others in pain when we are so vulnerable. To think that total strangers, for the most part, could come together and heal together is remarkable. It reminds me how much we humans have in common when it comes to important things.	None that I can think of

Table 10  
*G&C Ministry Budget for 2014*

<b>Revenue</b>	1500
MHR	
<b>Total revenue</b>	<b>1500</b>
<b>Expenses</b>	
Speaker	200
Trainings	300
Refreshments for events	100
Printing & advertising	100
Flowers for rituals	100
Musicians for rituals	400
<b>Total expenses</b>	<b>1200</b>
<b>Net income</b>	<b>300</b>

Table 11  
*SWOT Analysis of MHR Parish Nurse Program*

<p><b>Strengths:</b> Parish nurse will consolidate existing ministry budgets and volunteers and thus maximize parish resources.</p> <p>Professional leadership from nurse will improve psychosocial programs.</p> <p>Nurse will sustain own salary through grant writing activities.</p> <p>Project may sustain itself if it indirectly causes parish membership and donations to increase</p>	<p><b>Weaknesses:</b> Lack of current funds to initiate position.</p> <p>Historical problem in church with recruiting and retaining volunteers.</p> <p>Difficulties in finding nurse with right qualifications if ongoing funding is uncertain.</p>
<p><b>Opportunities:</b> Project coincides with community need for increased peer volunteer services to LGBT seniors.</p> <p>These needs may result in increased available funding and more collaboration with other local agencies (thus adding to project’s growth and future funding).</p>	<p><b>Threats:</b> Questions as to whether church’s current liability insurance would cover parish nurse activities.</p> <p>Uncertainty as to whether grants could pay nurse position once the grant-writer has been paid.</p> <p>There may be some conflict within the parish if some members dispute the use of funds for a parish nurse position.</p>

Table 12  
*Hypothetical Budget for Parish Nurse Program*

<b><u>Revenues</u></b>	<b><u>Year 1</u></b>	<b><u>Year 2</u></b>	<b><u>Year 3</u></b>
General donations to fund by church	5000	1000	1000
Donations from individual ministries	3000	3000	3000
Special event	2000	2000	2000
Revenue from trainings		200	1000
Private donations	2000	1000	5000
<b><u>Foundations</u></b>			
Foundation 1		20000	
Foundation 2			10000
Foundation 3			5000
Foundation 4			25000
<b><u>Total Revenue</u></b>	<b><u>12000</u></b>	<b><u>27200</u></b>	<b><u>52000</u></b>
<b><u>Expenses</u></b>			
Special event expenses	300	300	300
Advertising (for clients, volunteers & staff)		300	200
Training expenses	500	100	200
Materials and resources	500	500	500
Guest speakers			500
Staff salaries	12000	30000	30000
<b><u>Total Expenses</u></b>	<b><u>12800</u></b>	<b><u>31200</u></b>	<b><u>31700</u></b>
<b><u>Net Income</u></b>	<b><u>-800</u></b>	<b><u>-4000</u></b>	<b><u>20300</u></b>

**Appendices****Appendix A****Inclusion and Exclusion Criteria for Structured Group****Inclusion Criteria**

1. An ability to acknowledge the need for others (including the capacity to trust).
2. A self-reflective capacity (including an ability to reflect on one's interactions with others).
3. Role flexibility (the ability to lead and follow in a group).
4. An ability to give and receive feedback.
5. An ability to show empathy.
6. A toleration with frustration.
7. No pre-existing relationships with group members or leaders that might inhibit group work.
8. Realistic expectations about therapy and a motivation to change.
9. Ideally, grief treatment should not begin until at least three months after a loss.

**Exclusion Criteria**

1. Comorbid psychiatric conditions such as delusional or organic brain disorders.
2. Problems that require immediate management such as ideation to harm self or others.
3. Conditions that may need to be treated first (such as phobic disorders).
4. An inability or unwillingness to abide by group rules.
5. A leader's discomfort with a particular individual. This would not necessarily preclude excluding someone from a group, but discomfort with a potential group member is worthy of consideration. The leader would need to decide whether this discomfort might interfere with the leader's ability to support this client, or any other group member.

## Appendix B

### Contract and Ground Rules for Grief Group

*Commitment:* I understand that my commitment to the group is for all six sessions. The group will meet for 90 minutes every week. Unless there is a good reason, such as illness, I will be there each week. In the event of absence, I will notify the group leader prior to the group, and share these reasons with the group at the next available group session. I also recognize the importance of being on time, because lateness interferes with the work of the group. Should I decide to leave the group, if possible, I will share my reasons for leaving with the group.

*Responsibilities in the Group:* I agree to work toward learning more about my own and others' problems. I will try to be open and self-examining. I will not come to group under the influence of alcohol or drugs. I will speak from my own experiences and resist giving advice to other members without first asking their permission. I will resist criticizing other members. I will speak up as much as I feel comfortable and I will allow time for others to share.

*Responsibilities outside the Group:* Confidentiality is essential so that each member can feel safe enough to share. I agree that I will not share information outside of the group that might identify any group members. As much as possible, I will attempt to complete the homework assignments.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Leader Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix C

### Core Bereavement Index

Please circle your response to the below statement in regards to your loss. "X" represents your deceased loved one or some other loss.

#### A: Images and thoughts

1. Do you experience images of the events surrounding x's death  
Continuously  Quite a bit of the time  A little bit of the time  Never
2. Do thoughts of x come into your mind whether you wish it or not?  
Continuously  Quite a bit of the time  A little bit of the time  Never
3. Do thoughts of x make you feel distressed?  
Always  Quite a bit of the time  A little bit of the time  Never
4. Do you think about x?  
Continuously  Quite a bit of the time  A little bit of the time  Never
5. Do images of x make you feel distressed?  
Always  Quite a bit of the time  A little bit of the time  Never
6. Do you find yourself preoccupied with images or memories of x?  
Continuously  Quite a bit of the time  A little bit of the time  Never
7. Do you find yourself thinking of reunion with x?  
Always  Quite a bit of the time  A little bit of the time  Never

#### B: Acute separation

8. Do you find yourself missing x?  
A lot of the time  Quite a bit of the time  A little bit of the time  Never
9. Are you reminded by familiar objects (photos, possessions, rooms etc.) of x?  
A lot of the time  Quite a bit of the time  A little bit of the time  Never
10. Do you find yourself pining/yearning for x?  
A lot of the time  Quite a bit of the time  A little bit of the time  Never
11. Do you find yourself looking for x in familiar places?  
A lot of the time  Quite a bit of the time  A little bit of the time  Never
12. Do you feel distress/pain if for any reason you are confronted with the reality that x is not present/coming back?



A lot of the time  Quite a bit of the time  A little bit of the time  Never

### C. Grief

13. Do reminders of x such as photos, situations, music, places etc. cause you to feel longing for x?

A lot of the time  Quite a bit of the time  A little bit of the time  Never

14. Do reminders of x such as photos, situations, music, places etc. cause you to feel loneliness?

A lot of the time  Quite a bit of the time  A little bit of the time  Never

15. Do reminders of x such as photos, situations, music, places etc. cause you to cry about x?

A lot of the time  Quite a bit of the time  A little bit of the time  Never

16. Do reminders of x such as photos, situations, music, places etc. cause you to feel sadness?

A lot of the time  Quite a bit of the time  A little bit of the time  Never

17. Do reminders of x such as photos, situations, music, places etc. cause you to feel loss of enjoyment?

A lot of the time  Quite a bit of the time  A little bit of the time  Never