REGISTER ONLINE FOR NATIONAL **DEPRESSION** SCREENING DAY; FOLLOW THE LINK
TO FIND OUT HOW TO SCREEN THE PUBLIC FOR MOOD AND ANXIETY DISORDERS
Clinicians and others who wish to participate in National Depression Screening Day on October 7, 2004 can now register online at www.mentalhealthscreening.org . Those who register will receive a full kit of materials to screen the public for depression, bipolar, generalized anxiety disorder and post-traumatic stress disorder. Continuing Education credits are available for clinicians that conduct the screening. Also available: Community Response, a program of combined in-person and year-round online screening for alcohol, mood and anxiety disorders. Call (781) 239-0071 for more information.

Living Better Newsletter
At Patient Press, we are helping people live meaningful lives, despite their illness. We do so by providing high quality information to patients through books, web resources, and this newsletter. Below are articles designed to inform and equip people living with illness so that they may feel in control of their healthcare and their lives. For more information, visit our web site at www.patientpress.com .

Developing and Maintaining a Stress-Healthy Attitude
If you could take a safe, simple pill to make yourself immune to stress, you would probably take one without hesitation.
Unfortunately, there is no such pill. To control stress in your life, you must take emotional control of your life. You may be surprised how easily you can integrate stress-resisting beliefs into your life.

Nobody is completely immune to stress, but people's resistance to stress varies significantly. Some people's thoughts and beliefs help them resist stress; others fall into thought patterns that worsen the impact of stress. This table shows some key differences.

Harmful Thoughts/ Healthy Thoughts

I am out of control.

I can make good choices.

I have no influence over events in my life.

I can influence events around me.

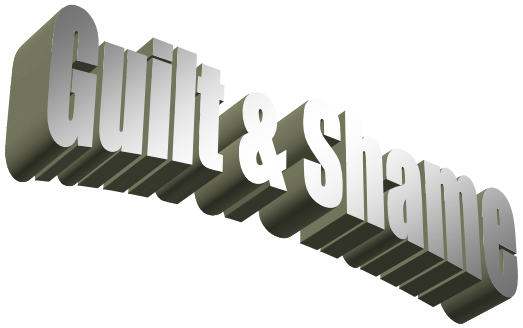
I can't handle this challenge.

I see challenges as opportunities.

I feel isolated and alone and don't want to be involved.

I am interested in being involved and have caring friends.

The University of Texas Health Science Center at San Antonio
Teleconference Network of Texas



The human experience

(Social Work series – August 20, 2003)

The Reverend Richard B. Gilbert, BCC, D.Min., FAAGC

A. Preliminary statements:

1. While all of us in health care are committed to the emotional wellbeing of those in our care (or otherwise who are our "customers"), social workers have both a unique opportunity and a very significant challenge as the watchdog for people's feelings. They are the interpreters of feelings, the advocate, and, with some frequency, the gatekeeper that both shouts the alarm that something is not right and who then facilitates the needed forms of care and support.

2. Feelings are just that -- feelings. They should bear no more than that. At the same time, they are the lubricant that enables the "motor" of our personhood to function and can become the culprit in sabotaging our health, wellbeing, safety and behavior.

3. Feelings are filters. Said another way, feelings are conduits through which pass our self awareness, self image, decision-making processes, vision, values and beliefs. Everything within us and around us is experienced through our feelings. When do the filters become clogged and thereby corrupting or disrupting the flow we call the human experience?

4. There is a difference between feelings and behavior. The move to one or another can be swift and deadly. Oftentimes we find ourselves responding to the behavior of another person (or ourselves) and then, only later, if we are timely and interested in this discernment, may begin to help address the feelings that may be at the root of the behavior and need of care and interpretation.

5. Feelings are just feelings. At their base expression they are neither positive nor negative. At the same time, feelings come with their own comfort level for us

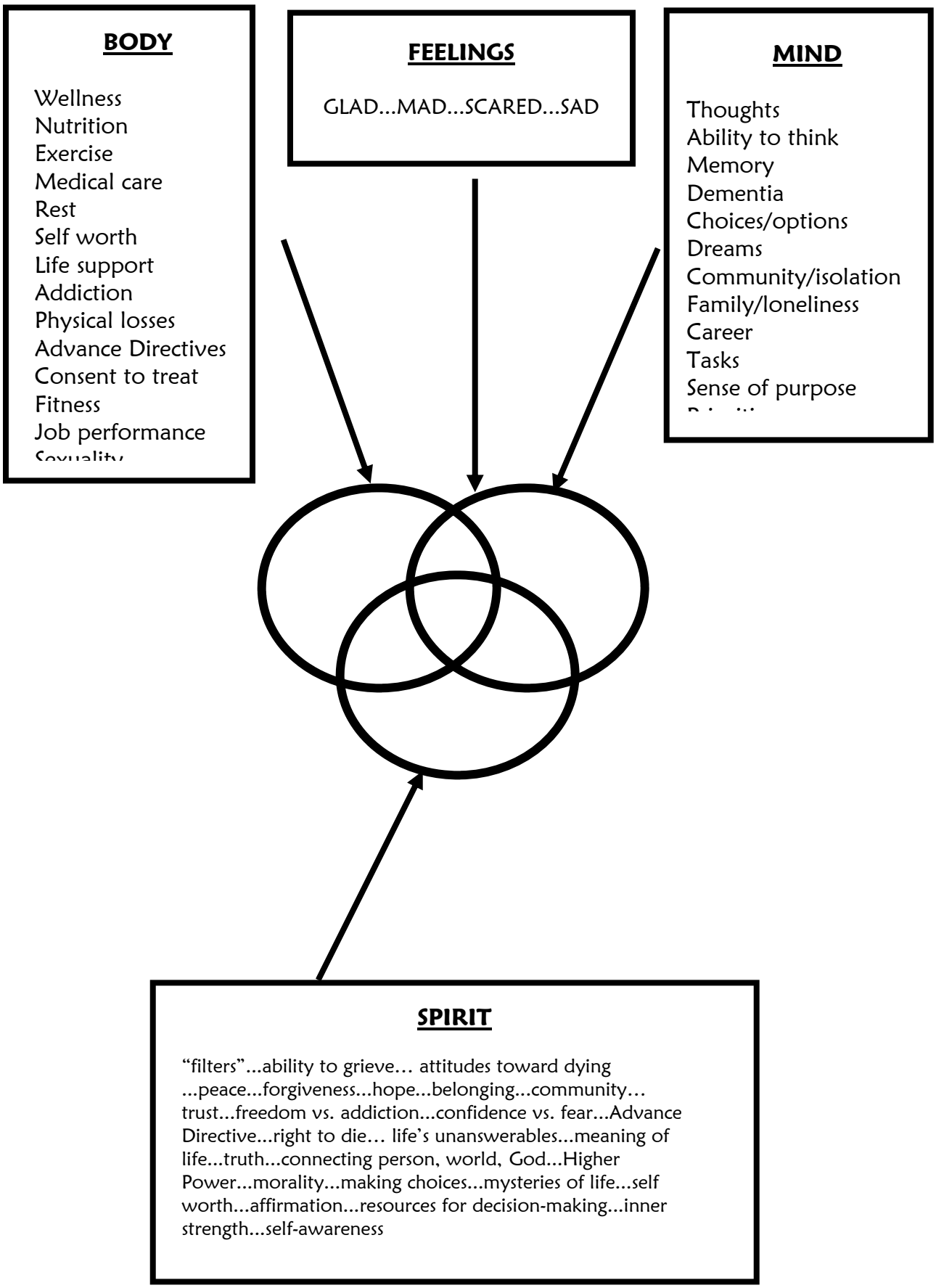
and experience significant filters just as they serve as filters. Some of those filters include our past experiences with that (or other) feeling(s), family of origin, current family or social context, world view and world issues, our health, the community (including its values and expectations), culture, our social network and religion (ours and that of others). In addition, most of us have something lacking in what we have been "taught" about feelings and their expressions. For example, are we ever really "taught" how to be "properly" angry?

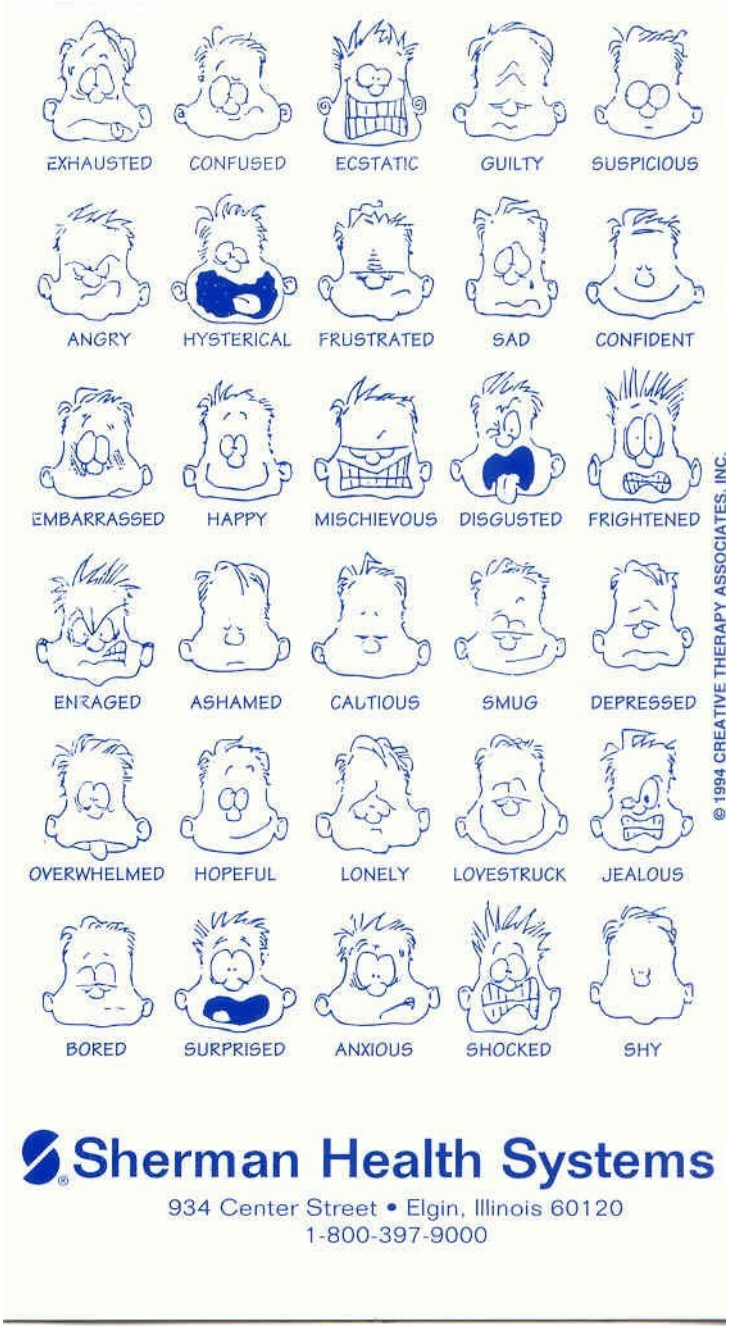
6. The pressures in and on contemporary health care produces myriad feelings that compromise and challenge our work. It is harder to stay healthy in health care as providers. At the same time, the needs of our patients/clients are ever present, now seem to be more demanding of us (for many reasons) and are harder for us to get to. We are really discovering the boundaries imposed upon us by managed care, our own values and culture, the limited resources in the community (especially around mental health issues), the value and culture of the person in our care, and, of course, time!

7. For all of us in health care, and, in very particular ways, this commitment as watchdogs or gatekeepers may be seen as the center of our frustration, consternation and even our downfall. They also can be the embryo of our rebirth or resurrection.

8. Within all of these statements come the unique challenges of *guilt* and *shame*, which both exemplify all of the statements above and also threaten or otherwise redefine them.

Notes:


BODY
Wellness
Nutrition
Exercise
Medical care
Rest
Self worth
Life support
Addiction
Physical losses
Advance Directives
Consent to treat
Fitness
Job performance
FEELINGS
GLAD...MAD...SCARED...SAD
MIND
Thoughts
Ability to think
Memory
Dementia
Choices/options
Dreams
Community/isolation
Family/loneliness
Career
Tasks
Sense of purpose
SPIRIT
"filters"...ability to grieve… attitudes toward dying ...peace...forgiveness...hope...belonging...community… trust...freedom vs. addiction...confidence vs. fear...Advance Directive...right to die… life's unanswerables...meaning of life...truth...connecting person, world, God...Higher Power...morality...making choices...mysteries of life...self worth...affirmation...resources for decision-making...inner strength...self-awareness



B. About guilt and shame.

1. It is important not to categorize feelings as "positive" or "negative." While we may choose to do that for ourselves, those decisions or choices are usually made based on the anticipation of or reality of what the experience of those feelings mean to us. In other words, the person experiencing the feeling, rightly or wrongly, assigns something as positive or negative. We dare not do this for another person, especially someone in our care. Oftentimes the "negative" is diminished when we have clarity and support. "Negative"

contradicts the neutrality of feelings, but that matters little to the person who falls prey to the "threat" of guilt and/or shame.

2. Feelings are neutral. They just are what they are. Our filters and the filters of the circumstances that prompt the feelings can give new meaning for us and defy that neutral zone.

3. Guilt and shame often mimic each other. They can emerge from the same story or circumstance and often appear to produce the same feelings, reactions and outcomes. Even some references use the words almost interchangeably. *They are NOT the same!* They are as different as external is from internal, and they can result in very difficult outcomes. They both can be deadly.

4. Guilt and shame are furthered compromised or complicated because they are frequently wrapped up in the standards and foundations that we expect "better things" from. In fact, these sources often produce guilt and/or shame while suggesting opposite gifts, such as healing, hope and peace. Mark the significance of these influences:

    a. The primary relationship
    b. The family
    c. Friends
    d. The church or other religious institution/community
    e. The standards, norms, expectations of the community
    f. Culture: our view for ourselves and how others view us
    g. The health care industry
    h. The government
    i. God

5. Guilt and shame, while sometimes "pumped up" by spiritual or religious expectations, behaviors or other influences, also can prompt people to turn to those very same expectations (i.e., a religious person, a religious leader, a religious community) for the expressed and unexpressed ritual needs that can become a pathway to healing.

> Righteous religion practices a form of parenting that is often conditional and thus detrimental to the spiritual maturity of the faithful. By means of frequent allusions to judgment and a questioning salvation, considerable anxiety is generated in believers over their possible exclusion by the parental church or the parental god. They know that failure to observe the rules can lead to unrighteousness or even damnation.
>
> An essential ingredient of Fundamentalism's or authoritarian Catholicism's approach to parenting is the instillation of fear. Frequent catechetical or scriptural references to sin, the devil, and hell are held over the heads of the possible nonbelievers as a constant threat of everlasting separation from the parental God. Fear compels people to consider themselves as debased, depraved, flawed, and in constant need of repentance, in order to assure eternal salvation and acceptance. By exploiting fear, guilt, unworthiness, and shame, the conditional parenting of authoritarian religions reinforces the notion that the church is good and that the childlike believer is bad.
>
> Members often feel guilty about not having met the expectations of God and their religion. Those who equate approval with love may sense themselves to be on the very of banishment if they have displeased the church or its parental leaders. They can feel unworthy and ashamed, as if they are no longer God's children. Spontaneous, natural, and perhaps even healthy displays of emotion are curtailed for fear of incurring parental censure and possible estrangement. Thus, by staying in conformity with their authoritarian religion, believers may be losing the voices of their souls. In other words, to ensure that they remain in parental favor, they

> surrender the voice of their true selves. Given the conditional parenting of the church, some members come to distrust their ability to make decisions. By devaluing their internal resources and wisdom, they have become alienated from their God-breathed intuition and the voice of the Spirit within. (Ritter & O'Neill, pp. 54-55)

C. About guilt

1. Guilt can be purposeful. It has a way of holding us accountable to our own self worth, values and the standards of the community (and others). It is the pathway for helping a person recognize that some actions or inactions are not what we want them to be and to facilitate change (healing).

2. Guilt can be real, that is, based on facts, or false, based on feelings, false assumptions or circumstances misinterpreted. Both are real to the person experiencing them, and both of them can be respected and released (forgiven).

3. While all guilt is "redeemable," it must first be respected by the person bearing it and the person seeking to facilitate its release. We too easily want to intervene, correct and relieve, and, in so doing, dismiss not only the feelings, but the person.

4. Guilt essentially has two meanings: the *state* of having done wrong and, second, a sense of discomfort or pain resulting from the *belief* that we have done something wrong. Some religions, including Christianity, think of guilt in terms of *state*, rather than a feeling. It is important to understand how some approach guilt and its implications for that person. Even when perceiving of guilt as "state", healthy spirituality has lots of room for feelings.

5. Guilt bears its on toxicity, especially when ignored. This can be fed into by the resources (cited above) that sometimes compound rather than comfort.

6. As caregivers we must understand and respect the viewpoint of the person experiencing guilt and also what we experience/feel when guilt is part of our story. The process (confession/absolution) through this guilt may come with specific rituals or non-traditional rituals, and there may be lessons learned and changes in lifestyle. The goal always a restoration to wholeness.

7. While we have used some traditional ritual words in discussing guilt, we must be careful when we use words like "confess." The person in your care might have a very different meaning for that word, and, especially when it is early in the care and the hidden implications of shame are undetected, our discussion of confess might heap more shame on the person in pain.

8. Common expressions with guilt: embarrassment, blame (others, self), feelings of regret, sense of remorse, feelings of obligation or responsibility for not doing the right thing or for failing others, increased health-related symptoms, changes in workplace behavior or performance, reinforcement of negative behaviors, irrational thinking.

9. People with a history of depression or other mental health issues, victimization or self destructive behavior are at particular risk when dealing with guilt or shame.

10. Some of the root causes of guilt:

a. irrational beliefs
b. sense of over-responsibility
c. people-pleasing behaviors
d. enabling behaviors
e. insecurity
f. perfectionism
g. pride
h. lack of healthy spirituality
i. fear of conflict
j. lack of assertiveness
k. resentment
l. self-destructive behaviors
m. addictive needs
n. over-dependence on others
(www.coping.org)

11. When dealing with guilt:

a. Acknowledge its presence and respect its existence.
b. Search out its root causes.
c. Identify filters that are influencing and possibly hampering
d. What filters and practices can comfort and facilitate?
e. Are there other responsible parties to deal with?
f. Are there people to whom we bear our regrets?
g. Is there a ritual to help us?
h. Are there parts of my self or story I want to change?
i. How can I affect that change?

D. About shame

1. Shame's source is essentially external. It is someone or something else judging me and saying "I am bad."

2. Some people, for various reasons usually beyond their control, are particularly vulnerable when it comes to shame.

3. Shame, in its extreme, is very destructive, driving from us our ability to feel good about ourselves and to make healthy choices for ourselves. "I am very disappointed in you" can quickly build up extreme toxicity.

4. Guilt brings the acknowledgement of wrongdoing and the desire to change. Shame, much harder to address, means coming to terms with the fact that someone else has said I am bad, has inhibited me in my living, and victimized me. Now I am forced to face my victimization and to seek (if I have any self esteem left) to address my victimization, choose to be a survivor, and keep myself safe. Perpetrators continue to remind us of our shamefulness. We must have help in identifying the perpetrator and keeping safely distant from the perpetrator. That is not easy to do under any circumstances, but especially so when there is the increased risk of violence.

5. How do we deal with the shame that we believe comes from God, a religious community or institution, a religious leader or a religious person? How do you, as caregiver, feel and react when these issues are presented?

6. How do we help the client (especially in the healthcare setting) advocate for themselves and the frequent symptoms of shame (pain, sense of dread, emotional outbursts, sleep and appetite disorders, etc.) which, under "normal" circumstances, are frequently missed or misunderstood by providers?

E. Special concerns and opportunities for social workers:

1. Are there special opportunities afforded you in this arena because you are social workers? Are there things you must be alert to?

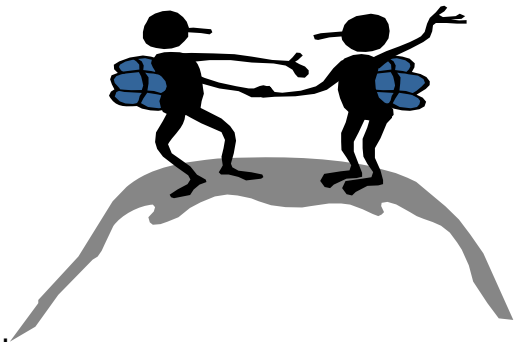
2. In what ways are you able to bring ritual, including religious ritual, into your work?

3. Do you have opportunities to work with chaplains?

4. Are there times that issues related to confidentiality hamper you in your work?

5. Does your workplace give you the time (and the encouragement) to address these issues?

6. Are your boundaries clear?



advice/inform
advise
invest
negotiate
confront
intervene
referral
closure
pastoral care
pastoral counseling
pastoral psychotherapy

F. Some examples for discussion.

1. A woman comes to you after first seeking a priest. "I went to him to confess that I have been a bad wife, like the Bible says, and I need to be better so that my husband won't have to beat me anymore."

2. A gay patient is admitted to your unit. He is dying. In assessing his needs you try to explore spiritual and religious issues and he both shuts down and very briskly rebukes you and dismisses you?

3. A cancer patient "confesses" that she has cancer because she smoked heavily.

4. A middle-aged man confesses how he has failed his family because he has a serious heart problem and is now disabled, thus unable to "properly provide for his family."

5. An elderly woman, in the care of a hospice, feels unworthy of heaven because, many years before, and for medical and social reasons, terminated a pregnancy.

6. The same elderly woman, but you believe that abortion is wrong at all times.

7. There aren't enough hours in the day to get all of your work done.

Additional notes:

Resources

You are encouraged to contact Abbey Press, 800.325.2511) and become familiar with the many titles of their Care Notes and Teen Notes (.75) and their very affordable books (usually $5). They are very user friendly for the people to work with on their own.

Albers, R. (1995). *Shame: A faith perspective.* Binghamton: Haworth.
Garrity, R. (1994). *O happy fault: Personal recovery through spiritual growth.* Mahwah, NJ: Paulist.
Ritter, K. & O'Neill, C. (1996). *Righteous religion; Unmasking the illusions of fundamentalism and authoritarian Catholicism.* Binghamton: Haworth.
Walsh, F. (Ed.). (1999). *Spiritual resources in family therapy.* New York: Guilford.
Whitehead, J. & Whitehead, E. (1994). *Shadows of the heart; A spirituality of the negative emotions.* New York: Crossroad.
Whitehead, J. & Whitehead, E. (1998) *Shadows of the heart; A spirituality of the painful emotions.* New York: Crossroad.

Some websites.

kidshealth.org/kid/feeling.
net-burst.net/guilty/guilt.htm.
www.abcfeelings.com.
www.equip.ac.uk/docs/guidelines/sexualabuse/guilt.html.
www.healthyplace.com/communities/abuse/lisk/guilt_shame.htm.
www.libertionpsych.org/guilt.html.
www.menstuff.org/books/byissue/feelings-anger.html.
www.soundfeelings.com/free/studying.htm.
www.watermankcommunity.org/ministry/celebrate/docs/cr_guiltandshame.pdf.

Today's presenter is The Rev. Dr. Richard B. Gilbert, BCC, FAAGC, executive director, The World Pastoral Care Center and Director of Chaplaincy Services, Sherman Health Systems, Elgin, IL. A frequent presenter for both the social work and chaplains series with the Teleconference Network of Texas, he has presented extensively throughout the United States and internationally. He earned the Doctor of Ministry in 1999 and was awarded the honorary LL.D. in 2002. He will defend his Ph.D. dissertation this fall. His two recent books are *Finding your way when your parent dies: Hope for adults* (Ave Maria Press) and *Healthcare & spirituality: Listening, assessing, caring* (Baywood). For information on the many programs of the World Pastoral Care Center, to further discuss today's presentation or to discuss the many employment opportunities at Sherman Hospital you are welcome to contact Dick directly at 847.429.2110, www.shermanhealth.com, dick.gilbert@shermanhospital.org or www.twpcc.org.