14 Bereavement Design

Revolutionizing Bereavement

Are you really using the latest technologies and methods?

This message is for CEOs and other Executive Managers. The adoption of revolutionary Bereavement methods and technologies normally will take your *position* and *personal* power. In short, it will take you "caring enough" that you will not settle for anything less than the best experience known for the patients and families you serve.

In Hospice, we are in the Death and Loss business. Please allow me to write candidly about this subject matter. We are often so close to what we do that I think we miss important things we could be doing to impact people's lives and the lives of all we come in contact with on a regular basis. I include myself as being one that regularly overlooks important things and one that has not always taken the time to stand back, reflect and then direct Intelligence and sensitivity towards the attempt to understand really what we do. Here I will to take a few steps in this direction…

Most Hospices, in my opinion, are "Clinical Models." That is, they focus primarily on the management of the physical aspects of pain, reducing and, if possible, eliminating it. And we have becoming outstanding at this. If a patient is in physical pain, I advise them to be very vocal about it. After all, we are expected and paid to be professionals in this area. However, once physical pain is at the desired level for the patient's expressed intentions of activity and interaction (although being pain-free would be an optimal goal), the alleviation or reduction of psychosocial or non-physical suffering should kick into high gear. But does it? We have a lot of resources directed towards non-physical suffering. Here I am going to focus on Bereavement.

The public assumes that we are experts in the Bereavement area. I think many Hospices believe they are as well. Based on personal and professional experience, I disagree. IF we are experts, then why don't we incorporate more modern methods and technologies? 99% of our movement uses traditional cognitive approaches, which are good, but are limited. Why not incorporate therapy modalities and technologies used by the most advanced experts in grief, loss and PTSD? I am referring to the use of *Standard* EMDR, Core-Focused EMDR, Hemi-Sync, IADC and the exploration of REM or the Dream State. Why so much emphasis on these? Because to RESOLVE grief, a positive "direct personal experience" must be

experienced that is based on “emotion” and not intellect, as grief is NOT intellectual. These highly emotional direct experiences can be facilitated…and it has been found that more can be done in 1-hour using these approaches than in 30 years of traditional cognitive counseling and therapies alone. Counseling is necessary, but it has to be done differently for people that are experiencing severe feelings of loss and grief. **I am advocating that counseling be augmented with new modalities, technologies and practices.** Why not use these methods and technologies if they are available and cost very little? Are we scared to challenge our Bereavement staff? I think you may be surprised how many Bereavement staff will welcome this attention as this area is becoming increasingly undervalued and overlooked. Loss is all around us. It’s part of our business. So let’s meet the public and community expectations and be great at it! Let’s provide more OPTIONS!

Why?

In my estimation, after 20+ years and working with nearly 900 Hospices of all sizes and regions of the country combined with my personal loss experience with 14 Hospice Bereavement experts, that less innovations have occurred in the non-physical and Bereavement domains than in many other areas of Hospice.

My extreme interest in Bereavement came from the loss of my son. He drowned in a freak accident right after graduating from high school. We were very, very close. I was in BAD shape. Initially, I stayed in bed and slept most of the time. Eating did not enter my mind. I wanted to find some way to escape the horrible pain. My mind was utterly “consumed” by the loss. I couldn’t think about anything else. I wanted desperately to get “better.” Then it dawned on me, “Hey, I work in Hospice! I’m working in a movement with experts in loss! They can help me!” ***14 Hospice Bereavement counselors later***, working with the “Best” in our Business…I realized I was screwed… All pretty much had the same bullet, “let’s talk about it” – “we have individual counseling, camps and support groups.” Counseling was the only real modality offered. I learned about a “new kind of normal” and “coping” – both very unattractive and depressing ideas. I was distraught and thought, “SOMEBODY has to know a better way than this…because I don’t know if I can go on living much longer with this much pain.” Virtually all of the experts indicated that it would take years to feel better and that I would never really get “over it.” So I took matters into my own hands and went on Amazon. I think I became their favorite customer! I ordered what has become a large personal library of books, CDs, and DVDs on the topic. I was so desperate to find out how and if I could ever really live again…or was my life over? I remember thinking “The Sun will NEVER shine bright again.”

I received one clinical book by accident. It was about EMDR and IADC. I read about people RECOVERING via incredible experiences. I had HOPE. I called Dr. Allan Boktin, author of the book. Dr. Boktin’s background was that of a clinical psychologist that worked for years on the trauma ward of the VA in Chicago, whose patients suffered from the most extreme cases of grief and PTSD. He had altered the EMDR protocol resulting in a highly predictable direct personal experience that he labeled IADC. I told him I was in horrid shape and asked him for

an appointment as soon as possible. I needed help desperately. I booked the next flight out, which was on a Friday so I could receive the therapy on Saturday morning. I remember praying to God earnestly that Botkin had tools the other 14 counselors didn't. I didn't want to talk about it again and re-traumatize myself only to have the counselor try to re-schedule yet another session. Long-story short, he used EMDR (Eye Movement Desensitization and Reprocessing) on me and then IADC. What does IADC stand for? I hate the name as I think the label hurts its acceptance. IADC stands for Induced After-Death Communication. The reason for this name is that when IADC is used, a high percentage (98% with PTSD/severe grief on the ward and 70% non-military in private practice) of the patients experience a "direct personal communication" with the deceased. It is a HIGHLY, HIGHLY emotional experience. It works whether you believe in it or not. It works regardless of your beliefs. It doesn't matter if you believe that the experience was real or a construct of the mind. The power of the experience can't be forgotten and it "cancels out" or resolves the grief, PTSD or deep sadness. And it only takes a SINGLE experience to do it. After that, it's over. You are OK. There are several reasons that Dr. Botkin speculates why the rate is higher for trauma patients on the VA ward, one of them being "high patient expectations." IADC is perhaps most effective when the patient enters the IADC session with *no knowledge* of what to expect.

This is a good place to offer some speculation about this phenomena. Is it really communication with the deceased or is it just a function of the brain? I say "Does it matter?" If a person is essentially cured and the grief is resolved, why fuss about it? If it is a "portal," I doubt it can ever be proven. People are having their pain resolved using this therapy! Here is a possible intellectual explanation. A loss is an emotional experience. Therefore, it takes an emotional experience of the same or similar magnitude to cancel out the feeling of loss or grief. A loss is NOT an intellectual experience. Otherwise, I could say "I lost my son. Great! Now I don't have to pay for college or have to worry about him anymore!" Clearly, this is not the way humans handle the loss of loved ones. To me, traditional cognitive counseling is the equivalent of using a hammer when you need a screw driver…you need the right/better tool. A person can't "think" or "talk" their way out of grief, as grief is NOT an intellectual process… So why address this pain via thinking through it and talking about it…repeatedly? Again, I'm not saying not to talk about it. Counseling is essential! But what a counselor steers a person to and how you go about counseling must be different when using these tools.

I did IADC and…..BANG! I had an experience that reshaped me. It was so dramatic and powerful! My grief was effectively gone!!! Sure, I miss my son, but I'm OK with it and he's OK! It spiked my awareness of spiritual things and made me ready to explore life, even more fully than before because I know that everything is under control! I went back to work with full force. Then I started getting requests from people in Hospice about my apparent "overcoming" of a tragic situation. "How did you get though it so well?" "You seemed to get over it so quickly!" These requests happened a lot and still do. I always explain that "I am no expert by any means, but I can share with you what really helped me." In 100% of the cases, the results have been profound. I'm amazed…

At this point, I have shared and shared and shared what I know about this with many Hospices via articles, manuals, I have brought the world-leading experts together at my personal expense to work with Hospices and Revolutionizing Bereavement is part of every Model Workshop (How can a Hospice have any claim of being truly "World-Class" without using these Bereavement practices?). Yet, in the large, Hospices continue to disregard these modalities.

Resistance is great…as is the case with most significant but "different" ideological breakthroughs throughout history (Consider the resistance to Penicillin!). HOWEVER, of the brave Hospices that have had the courage to adopt any of these modalities and technologies (EMDR, IADC, Hemi-Sync and Advanced Exploration of the Dream State) with diligence, the results are just like my own… They are devastatingly effective and change lives, often profoundly. And these results are LONG-TERM. That is, they hold up over time.

Here is a brief description of each of these treatment modalities and technologies. Also, know that you can always call me directly to discuss this topic, as I feel very, very strongly that a "Revolution in Bereavement" is necessary from a mission as well as from an economic perspective.

EMDR (Eye Movement Desensitization and Reprocessing) – This modality was discovered by Dr. Francine Shapiro in 1987 when she was walking in the park and she realized that eye movements appeared to decrease the negative emotion associated with her own distressing memories. She simply noticed that "she felt better" after she moved her eyes back and forth. This insightful observation spiked her curiosity and she ultimately developed this therapy around it. It was adopted by many VA systems, including the VA in Chicago. At first, the physicians and clinicians were skeptical. "How can moving your eyes back and forth help?" But positive outcomes resulted. EMDR has been described as the feeling of "moving the pain" or "making the event distant" so that it can be touched and revisited without or with much less pain. Any SW (MSW or LSW) can be certified in EMDR. There are different types of EMDR including *Standard* EMDR, Core-Focused EMDR and Core-Focused EMDR Plus *Standard* EMDR to Enhance Receptivity. The Core-Focused is an important distinction that should be used by Hospices.

IADC (Induced After-Death Communication) – Though this label is a bit spooky, this method is what really worked for me. Core-Focused EMDR is necessary as a prerequisite, and then IADC is performed. It was IADC that resolved my grief and introduced me to a new way to view the world. This altered EMDR protocol creates a predictable HIGHLY emotional experience where the deceased usually communicates with the patient. The communication can take many forms, but the messages usually have the themes of – "love," "all is well," "get on with your life," "I'm great," etc. If a conversation or interaction with the deceased is not finished, sometimes IADC can be initiated again immediately and the conversation/interaction can be resumed! Is that incredible or what? The technique works for 70%-98% (depending upon the type of patient) of patients regardless of the patient's belief system. Atheists usually come out of the experience saying "That was weird!" They rationalize that it was "mental" or a "brain" thing…but their grief or PTSD is resolved. Whether these are real visitations or some kind of a

portal or are simply mental constructs does not matter. IADC relieves suffering of those with severe grief, PTSD or people that are just really sad. What is the demarcation of PTSD and severe grief? I don't know. I have been attacked by some Hospice Bereavement experts about this… All I know is that I've witnessed people that were really sad resolve their pain…in an amazingly short period of time… Any person that has been trained in EMDR can be trained in IADC. For a better understanding of EMDR and IADC, here is a link to an interview in a park with Dr. Allan Botkin - www.youtube.com/watch?v=_Jnipb9rTnQ.

Hemi-Sync – This is a binaural technology with more than 50 years of science and research behind it. It has been used to create highly, emotionalized personal experiences as it alters consciousness. This technology enables a person to be in an "in-between" state for extended periods of time (between the sleep-state and waking state of consciousness). Thoughts and impressions are much more fluid in the "in-between" state. I have had several "experiences" using Hemi-Sync…and they were profound. This technology has been and is currently used by branches of the US Armed Forces to help soldiers with PTSD as well as with Intelligence officers in the Pentagon. The complex tones create a "whole brain state" where both hemispheres of the brain become much more coherent. It can be used on deaf people when placed on the throat area. A newer technology is also available called **SAM** (Spatial Angular Modulation), which uses a single sound wave to speed up or slow down the firing of synapses in the brain. MVI worked with Monroe Products to create Hemi-Sync CDs specifically for Hospice, Ocean Surf and Relaxation & Comfort. If your Hospice is a Network client and you want a copy of either or both of these, please contact the MVI office and we'll get them out to you. Hemi-Sync was one of the last projects that Elizabeth Kũbler-Ross was involved with and she stated that she had one of the most significance experiences of her life using it…and she wanted the Hospice world to use it as well. The Hemi-Sync project she was working on was called Going Home. It can be ordered directly from Monroe Products at (434) 263-8692. Also, I use Hemi-Sync when I want to increase my problem solving abilities and creativity. The truth be known, most of my most significant advancements as a person and in the idea realm have come from Hemi-Sync including the MVI Executive Conference Center as well as many MVI products.

Exploration of the Dream State – How much comfort comes from the Dream State or REM? Is there a reason the bereaved want to sleep a lot? What about "visitations" from the deceased in this state of consciousness? It seems that a great deal of grief is resolved in the Dream State. Yet, society discounts this state of consciousness and throws it away like trash. This modality is more difficult to "facilitate" than the others, but its comforting effect is huge. Ask any person that has had the "Dream Visit" from a departed loved one with comforting messages if they were impacted?

What are the commonalties of all 4 of these treatment modalities and technologies? There are a few, (1) eyes (or hearing) being moved back and forth while holding a specific topic or idea in mind, (2) highly emotional direct personal experiences are created and (3) there is a "surrender" or "release" point where a person let's go and the experience happens. Perhaps

the back and forth eye movements speed up the integration process of the brain? We can only speculate.

As I write this, I ask myself “Who am I to recommend this?” I certainly am no expert. I’m just a guy that had a significant loss, that explored virtually everything that was readily available, dug deeper and discovered that there were things out there that really, really helped… Perhaps this will help others that are suffering too…

It has been estimated that 70-80% of human suffering is psychosocial or non-physical in nature. This is a very subjective estimate. However, I think we would all agree that it is a large amount. Yet, how far does a typical Hospice go to relieve suffering in this domain? What arrays of tools are being utilized? Hospices put tremendous resources into this area for sure employing Social Workers, Spiritual Care, Bereavement and Volunteer team members. Each of these areas should be upgraded on a regular basis with innovations from Hospices operating in the 90th percentile. But often they do not receive the same attention as the “Medical” model. Nurses and Physicians have a continual stream of new medications and adaptations of clinical practice thanks to pharmaceutical companies and governmental quality pressures. Hospices Aides are reinventing their roles like wildfire. Yet, the psychosocial area remains largely the same based on my experience with hundreds and hundreds of Hospices over the last 20+ years. The amount of depression, loneliness, sadness, anxiety, stress and other suffering of this non-physical nature remain high. This is the human condition. I do not speculate as to the levels of non-physical pain, whether it is increasing or decreasing for it has

always been seemingly high. Psychosocial pain is often the "subtle" pain, difficult to measure, diagnose, treat and even define because we can't see it and often we rely largely upon feedback from the other person to evaluate our methods. Therefore, it is perhaps the most difficult of all pain to address. In fact, if we could solve non-physical pain, much of humankind's woes would disappear…no small task for any group, let alone a Hospice. However, the fact is that we CAN have tremendous impact on non-physical suffering. Each of our Hospices has the ability to reduce distress in this non-physical dimension not just slightly, but by truly significant amounts. Yet, it is not recognized as possible by much of society. The Bereavement function itself is devalued by Medicare and health systems as evidenced in the way we are paid. Why? Because they don't really understand its impact nor believe that we have reliable, effective solutions/practices that provide measurable results. In short, they [we] have great difficulty understanding it and getting our arms around it and its implications.

Guilt and shame, two of the most destructive feelings a human being can experience on a long-term basis, along with suffering from grief, are examples of suffering that Hospices can dramatically impact with ***proven practices***. But these practices are NOT typically utilized in the Hospice community.

In this section of the workbook, I am suggesting that Hospices move away from being myopically focused on physical pain and truly move towards a holistic model of mind, body and spirit. You may think, "Andrew, we already are?" Perhaps this is true. But I will put forth a "few" of the VAST number of things a Hospice can do in this area. I will catch my usually amount of flack (one of the reasons I wear black, besides the sheer convenience of coordinating matching clothes), but I feel that this subject matter is utterly important in our work and is not given nearly the amount of creative focus it deserves. First, though, let's briefly explore a few of the core topics that cause suffering in the non-physical domain. I will reduce this brief discourse to three intermingled elements – Death, Loss and the Desire for Change.

Death and Loss is our business. We see these with every patient and family we serve. We feel their effect within ourselves and see them in the lives of those we love. The suffering is deep and difficult to express. Death and Loss can be the same or different as "loss" happens every day to various degrees. Loss can come in the form of "mini losses" that cause a slight feeling of sadness or be "titanic and gargantuan" where the non-physical suffering consumes a person… literally, perhaps limb by limb or whole. Bereavement work is a constant in our lives on some level as losses happen every day and at every turn in one form or another.

The Desire for Change is also within every person. We all want to become better or perceive this as occurring in our lives. The feeling or belief that one cannot overcome the loss(es) or non-attainment of goals is the root or near the root of non-physical suffering. As we assist in the implementation of a true "Model" approach to operating a Hospice, we hear constantly "People do not like change." This belief is simply not true. Perhaps it should be more clearly articulated such as, "People don't like certain types of changes." All people desire change in one way or another. On an organizational level, if a good idea is suggested along with a plausible plan of implementation, most people will go with the change every time! When you

look at how people conduct their lives, especially regarding the use of their leisure time, they are often seeking to improve themselves whether it is cooking, raising children, discovery of self, making the yard more beautiful, using a new app on their phone, selecting clothes and makeup – all efforts to improve or make changes for betterment. We can't help this internal motivation for advancement because the desire to improve is in our nature, our DNA, our spirit. It is within this Desire to Change that lays the ability for us to reconcile our "wrestle with death and loss."

On a person note, I CHOOSE to see the world as a continually improving thing. A loss is a new beginning, a driver of change and a positive evolutional event in my life. Yes, I get depressed sometimes, but I don't like to stay there very long so I get up and get moving again. (I am constantly amazed how much can be accomplished by people that don't feel well!) I agree with Einstein that our purpose here is to help each other in our given and developed capacities. We are here to learn and then teach what we learn through what we say and, more importantly, what we do. Most of us learn far more through hardship and struggle than by things that are accomplished easily or with minimal effort. Therefore, this world is perfectly designed! (We also need accomplishments, for sure, to build "confidence" – that important quality that permeates the Model). [I released a music CD called "I Am" that includes an interview with a radio personality exploring these ideas in more detail if you are interested.]

As to not write an epic, here are a "few" practices (we have discovered many, many more) that I think a Hospice should not only consider, but actually do (at least this is what we are doing when asked to assist in the creation of a Hospice Model).

- Watch MVI's 23 minute video on Bereavement and the Model. This is available on the MVI Portal or via the attached link.
- Watch The Model Social Work Visit, Spiritual Care Visit videos as well after watching the Model Bereavement Visit on the MVI portal. [Jonathan attach a link]
- Add LifeDisk or life recordings as a service your Hospice provides shortly after admission. Patients can give tremendous comfort to themselves and their loved ones during these digitized recordings and these high-quality recordings will continue to provide comfort forever…(see April 2012 Flashpage for the latest techniques and equipment)
- Offer EMDR (Eye Movement Desensitization and Reprocessing)
- Offer IADC (Induced After-Death Communication – an extension of EMDR) Watch the attached YouTube interview with Dr. Al Botkin – EMDR & Induced After-Death Communication IADC) http://youtu.be/_Jnipb9rTnQ Also, I would recommend the book Induced After-Death Communication by Dr. Botkin. **I HIGHLY RECOMMEND THAT THIS VIDEO LINK IS VIEWED BY ALL SERIOUS BEREAVEMENT EXPERTS AND SOCIAL WORKERS.**
- Add Hemi-Sync® products, Relaxation and Comfort and Ocean Surf to your Model's Menu of products and services as well as SleepSonic Pilows and/or SleepPhones (all available from Monroe Products). These audio technology products were created

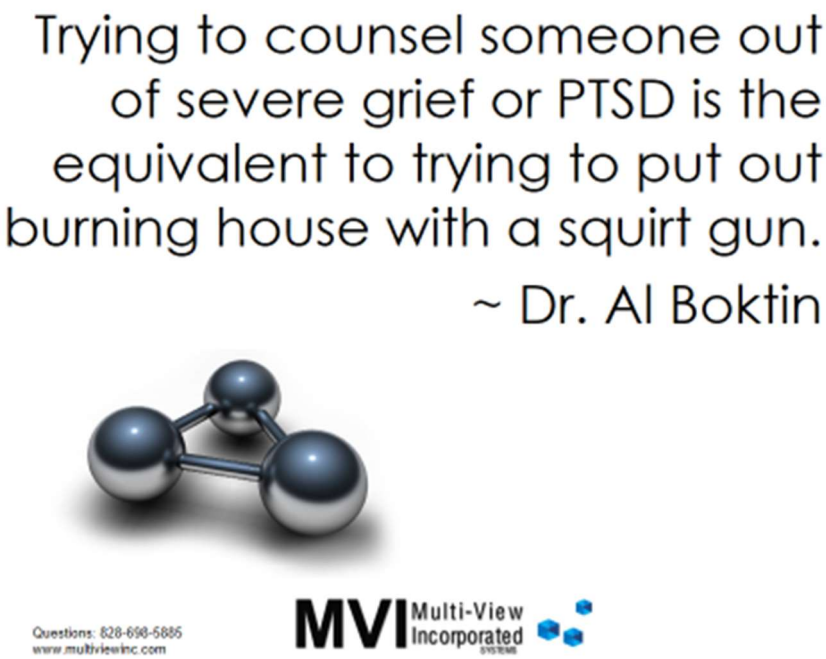
specifically for Hospice patients and caregivers via a joint collaboration between MVI and Monroe Products. They can be ordered directly from Monroe Products at 1-800-541-2488.

- Offer patients There is Great Hope That We Continue – This audio file is an excerpt from Dr. Charles Tart when he was working with Elizabeth Kübler Ross and Monroe Products on the Going Home series at MVI released in 2011. This message (via MP3 or CD) will provide great "hope" for patients and caregivers that fear physical death. This is a "very open" and "non-threatening" message that simply opens up possibilities of life after death based on research. This is available on the MVI portal. [Jonathan attach a link]
- When counseling, explore the sleep state with patients and caregivers. Provide "dream journals" or include them as part of the Caregiver Documentation Journal. Use this information and do not discard this resource as our society often does. Our dreams are an essential state of consciousness that offers great insight into our "truest self" and perhaps the dimension beyond. Dr. Robert L. Van De Castle, author of Our Dreaming Mind, would be a great resource as well as his and other's work at the University of Virginia.
- Offer explorations with lucid dream work. I have not seen this done with patients, but with those in grief and it can be taught. These dreams could make great counseling topics.
- Offer "breathe work."
- Offer meditation, incense, and other relaxation inducing techniques.
- Offer courses on fascinating spiritual topics. (We have a substantial list that Hospice's are starting to incorporate into practice.)
- Offer guided imagery via media.
- Simply change the way your Hospice corporately views' death. This one single change can make the subject of death so much lighter and reduce burn-out.

If you do these things, you will not only find that you will achieve better outcomes, you will also achieve these outcomes at LESS cost. Counseling efforts will be more productive as you will be incorporating more "products" that provide consistent experiences that facilitate the growth/transition process of patients and families. It is a flawed idea that you have to spend more money to increase quality and achieve better outcomes. We are paid enough in Hospice to provide a World-Class experience. Increasing quality is more of a matter of HOW we direct and utilize our resources. Using these products and techniques will actually diminish burn-out of Social Workers, Bereavement Experts, Spiritual Counselor and Volunteers as these disciplines will have "tools" that they can depend upon for efficient use of time and that promote "reinvigorating interactions" with those they serve as their work becomes increasingly interesting and valued.

If your Hospice relies primarily on counseling as its mode of care for psychosocial or non-physical pain, I would venture to say that your patients and family are being deprived of a vast array of effective and cost-reducing practices and tools. With this stated, *I am not in any way*

diminishing the need and benefits of skilled counseling, but I am saying to "*augment your counseling activities and go beyond what traditional Hospices offer.*" You cannot think your way out of grief. You cannot talk or counsel your way out of grief. "Resolution of grief" (NOTE: I'm not using the word "coping") comes from direct experience of the bereaved…and this private experience must come directly to or within a person and will be facilitated via many of the means I have listed. I know grief too well I am afraid…and thus I offer these ideas or combinations of ideas that may help.



In order to achieve resolution of severe grief or PTSD, the patient must have a direct personal experience that is equivalent of the loss experience.

~ Dr. Al Boktin

Questions: 828-698-5885
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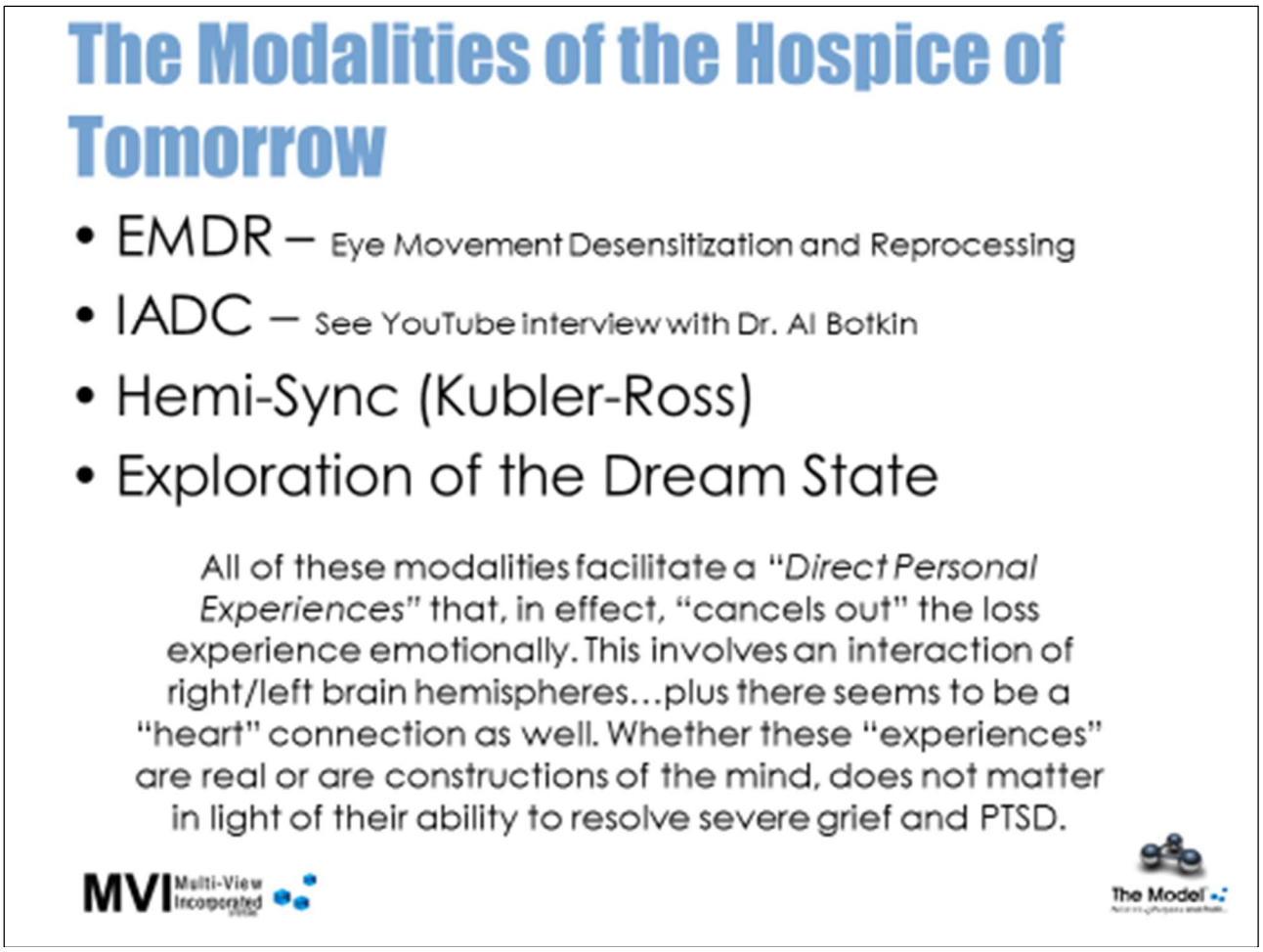
The Modalities of the Hospice of Tomorrow
• EMDR – Eye Movement Desensitization and Reprocessing
• IADC – See YouTube interview with Dr. Al Botkin
• Hemi-Sync (Kubler-Ross)
• Exploration of the Dream State
All of these modalities facilitate a "Direct Personal Experiences" that, in effect, "cancels out" the loss experience emotionally. This involves an interaction of right/left brain hemispheres…plus there seems to be a "heart" connection as well. Whether these "experiences" are real or are constructions of the mind, does not matter in light of their ability to resolve severe grief and PTSD.
MVI Multi-View Incorporated
The Model

CDs for Patients, Caregivers & Hospice Staff

MVI Multi-View Incorporated

The Model

These can be ordered directly from Monroe Products at (434) 263-8692. Ask for these titles specifically or if you want to see the result of Elizabeth Kubler Ross's work in this area, request one of the *Going Home* series.

www.Hemi-Sync.com

