Accommodation To Violent Dying

A Guide to Restorative Retelling and Support

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VIOLENT DEATH BEREAVEMENT SOCIETY

Mission: The Violent Death Bereavement Society (**www.vdbs.org**) serves as a centralized forum of information and training for service providers of loved ones and family members after violent death with the following objectives:

1) ***Training*** – to sponsor lectures and workshops for service providers caring for loved ones and family members after violent death to plan and initiate community-based support services including clinical guidelines for support, screening and focused interventions.
2) ***Referral and Consultation*** – to maintain a national registry of experienced clinicians, service providers and regional experts for consultation.
3) ***Study and Research*** – to maintain an updated resource of research reports and literature on the occurrence, recognition and support of bereavement after violent death.
4) ***Affiliation*** – to form a non-profit organization of service providers with elected officers and board to organize and sponsor periodic regional and national meetings for updated lectures, workshops and symposiums on violent death.

The Violent Death Bereavement Society is a consultative resource providing contact information on innovative interventions, research design and an updated resource of references.

For more information you may visit our website: **www.vdbs.org**

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I. INTRODUCTION TO RETELLING VIOLENT DEATH

Violent dying from homicide, suicide, accident, combat or terrorist attack accounts for nearly 10% of annual deaths worldwide, and clinical studies document the commonality of a syndrome of combined trauma distress (intrusive thoughts, flashbacks and dreams of the dying – even though the dying was rarely witnessed) and separation distress (pining and searching for the deceased) in close friends and family members (Rynearson, 1999). This syndrome usually diminishes within months of the death, but may be associated with a prolonged and dysfunctional bereavement syndrome in a minority of family members and friends (Amick-McMullan A., Kilpatrick, D., Vernon, L., Smith, A., 1989, Parkes, C., 1993). Mothers of children who died violently are at highest risk for prolonged trauma distress (20 % remain highly traumatized 5 years after the death) because of their intense care giving attachment, no matter the age of the child (Murphy, 1999). Young children who witness the violent dying of a family member are also at high risk for prolonged distress, presumably because of their intense dependent attachment upon the deceased.

When the violent dying is deemed a criminal act (terrorism, homicide or criminal negligence) the media, medical examiner, police and judicial system begin a mandatory, public announcement and inquiry of the dying to find and punish whoever was responsible. The public retelling of the violent dying story is very different th33an the public respect for the family's privacy in retelling a natural death. Once declared criminal, the public and media demand a spotlighted reenactment of the dying that in, some cases, becomes voyeuristic. Public repetition of the dying reenactment may heighten the distress of friends and family members.

Available Interventions

Beginning in the 1970's, peer-led support groups offered the first interventions specific for friends and family members bereaved by violent dying. While these groups continue to provide crucial services of advocacy and support, there are no criteria for participation, formal agenda, session format, explicit goals or limitation on sessions or membership. In the absence of standardization of intervention procedures and eligibility criteria, it is difficult to determine the efficacy of peer-led interventions.

In 1978, one of the authors (Edward K. Rynearson, MD) volunteered as a psychiatric consultant in peer led support groups for family members after homicidal death and a subsequent report (Rynearson, 1984) described the specific syndromal combination of trauma and separation distress he noted in dysfunctional family members. The association of intense post-traumatic responses with non-accommodation also demonstrated the limitations and complications of an open ended, unstructured group format.

The dropout rate for new members was unnecessarily high because intensely distressed subjects were not screened for traumatic co-morbidity and could not tolerate immersion in the violent dying stories of the other members. With that recognition, the group leader was urged to assess the level of trauma in potential members and provide those with high trauma distress individual support before being prematurely exposed to the stories of other family members. This insight served as a screening guideline for the group leader and led to a more detailed appraisal of the psychological imprint of the dying imagery and its reprocessing as a story during treatment.

While the clinical literature on the psychological effects and management of bereavement after violent death has been largely descriptive and anecdotal, there are several more rigorous and promising research and outcome studies of adolescents and adults grief stricken following violent dying measuring the effects of time limited-interventions for grief related dysfunction:

1) Pynoos and collaborators at the National Child Traumatic Stress Network include an extensive list of references on their website (www.NCTSN.org) describing school-based protocols for screening and measurement of time-limited interventions for children exposed to violent death associated with homicide, disaster and warfare.

2) Salloum and collaborators established a community-based program for adolescents in a crime-ridden, intra-urban setting, and developed a time-limited, group intervention for adolescents with bereavement after violent death. Following a decade of pragmatic, school-based protocol for identification and support of highly distressed youngsters, Salloum and co-workers completed a series of studies documenting its effectiveness (Salloum – 1998, 1999, 2001, 2005).

3) There have been recent reports (Shear – 2001, 2005) demonstrating the effectiveness of individual, time-limited intervention with adult subjects presenting with complicated grief.

Though the sample from the most recent study was heterogeneous (subjects presented with complicated grief after natural death and violent dying) those subjects grieved by violent dying were responsive to the author's specific intervention – more effective than Interpersonal Psychotherapy (IPT) with which it was compared.

We have treated over 2,000 family members through a community-based protocol with a dynamic clinical model, a systematic process for screening for high-risk and specific short-term group intervention (Restorative Retelling) to deal with the combined distress of trauma and grief associated with prolonged and intense violent dying imagery (Rynearson, 1999) herein described.

The Retelling Dynamic: A Basis for the Clinical Model

Since a small minority of violent deaths are witnessed by family members or loved ones, they are in the ironic position of retelling the story of a violent dying in which they played no part. Further, it is the repetitive, imaginary retelling of this dying story, lasting for many months that is associated with dysfunction and need for assistance (Rynearson, 1995). Since the dying "story" is paramount in non-accommodation, retelling and revising the story is a primary focus in restoring the patient and a conceptual model has been developed to clarify the process of reconstructive narration.

A fundamental way the mind first processes violent dying is to imagine and retell it. The story form is a basic mental paradigm of coherence. Constructing a story around an experience of any kind, including a traumatic experience, brings order and meaning (Neimeyer, 2000). The story form provides a beginning, middle and an ending – with characters who share and mutually resolve needs and conflicts, and the story celebrates and endorses social values at the same time. Apparently after a violent dying, the mind reflexively relives the dying moments of the person as a story, and because there was a caring relationship, it is intolerable to imagine their terror and helplessness. There is no way that the violent dying of a loved one can end with meaning, only an empty absurdity. This never should have happened.

Unwitnessed, the imaginary action of the violent dying story assumes a surreal perspective, fashioned from fragments of criminal justice and media reports, distorted by vivid, private fantasy. The imagined story of the victim's dying cannot fully register as "real".

The **reenactment** story of the violent dying is a primary response, and recurs as a repetitive thought, flashback or nightmare for days, weeks or months after the death.

There are other secondary stories that occur concurrently and their purpose is to make the dying "unhappen":

- Story of **remorse** – ***"I am somehow responsible for the dying. I should have prevented it from happening, and I wish that I had died instead."***
- Story of **retaliation** – ***"Someone else is responsible for the dying. I am going to find that person and get even."***
- Story of **protection – "*I can't allow this to happen to anyone else who is close to me. I need them close to me so I know that we are safe."***

These repetitive stories fill the mind. Most family members and loved ones are able to accommodate by engaging in a spontaneous restorative retelling and meaningful reunion rituals of the deceased with family, friends and community. The story of the life of the deceased gains ascendancy and becomes stronger than the story of their dying

When a violent death occurs from an act of terrorism, suicide, homicide or accident, the coroner, criminal justice agencies and the media are all involved in retelling the dying to obtain retribution for the deceased and punishment for the perpetrator. Sometimes the public retelling of the dying by all these entities is inaccurate, insensitive, misleading and complicates the private retelling. It is difficult for the family member or friend to finally accommodate to the dying until this public processing of the dying story has been completed.

Trauma and Separation Distress to Violent Dying

The Restorative Retelling (RR) model proposes that trauma distress and separation distress are concurrent responses – trauma distress to violent dying and separation distress to death. While the thoughts, feelings and behaviors of trauma and separation distress are not specific, they are roughly separable into two syndromes:

Table 1

	Trauma Distress	**Separation Distress**
Thoughts	Reenactment	Reunion
Feelings	Fear	Longing
Behavior	Avoidance	Searching

Clinical dysfunction is associated with repetitive, intrusive, and enervating images and stories as the memories of the deceased; the dying and the observing self simultaneously converge and merge:

- *Dysfunctional images and stories of the **deceased** contain their terror and helplessness as they were dying.*
- *Dysfunctional images and stories of the **dying** recur as an involuntary witnessing of a disintegratory drama that cannot be controlled.*
- *Dysfunctional images and stories of the **self,** persist as being remorseful, retaliatory, or ultimate protector for remaining friends and family members.*

The short-term, focused intervention described in this manual is designed to specifically address the dysfunctional retelling of traumatic reenactment and possessive images of remorse, retaliation and need to protect.

Restorative Retelling (RR) intervention is designed to moderate internalized trauma and separation distress. Trauma distress takes neuropsychological precedence over separation distress. Since the dysfunctional images and stories are primarily related to the trauma of the dying, supportive strategies to deal with trauma distress are the initial goals of the intervention. Before dealing with separation distress, someone who is highly traumatized by violent dying needs to be stabilized and, intervention initially focuses on restoring the subject's capacity for maintaining a sense of **safety, separateness and autonomy** from the dying experience. We call these preverbal capacities, **resilience**, and without them the subject will be overwhelmed in the dying imagery and stories. Without resilience the observant self risks disintegrating in the same, nameless swirl of terror and helplessness as the deceased.

The intervention is applied in a closed, time-limited group (two hour sessions for 10 consecutive weeks) with a written agenda and format (Rynearson, 1999). Potential members are screened to assess for co-morbidity (disorders of depression, PTSD, substance abuse) and exclusion criteria (active psychosis, active substance abuse, intellectual handicap, severe Axis II disorder).

The theory, agenda and goals of the intervention are directly shared with participants through discussion and handouts. We propose to each member that modification of dysfunctional images and stories of the deceased, the dying, and the self, diminish**es** the distress responses of trauma and separation.

Intervention first focuses on strategies to restore resilience, then exercises to retell and celebrate the living memory of the deceased and self, then exercises of "exposure" and retelling of the dying story. This restorative retelling reestablishes a vital image of the deceased and self that transcends the dying so the family member or loved one can reengage with their own living through and beyond the stories of the violent dying (Rynearson, 2001).

The intervention is based on the clinical fundamentals of early crisis support followed by enhancement of skills for stress reduction before re-exposure to the retelling of the violent dying story.

Evidence of Effectiveness

We have completed open trial outcome studies on over 200 adult outpatients who sought and completed Restorative Retelling group intervention for distress secondary to violent death at one of two sites - Seattle (Rynearson 2006, Rheingold 2015) or San Diego (Saindon 2014) from 1999 through 2011.

Preparatory to a controlled outcome study, these studies were confined to measurements of change in distress before and after an open trial of the intervention to: (1) document an association of diminished distress with intervention, and (2) ensure that intervention was associated with a low rate of complications and drop out.

It should be emphasized that only a tiny minority of community members spontaneously seeks psychological assistance, so these subjects represent a biased sub sample of the community who were highly distressed by the violent death (Rynearson, 1995).

All subjects were assessed in a semi-structured, individual interview to provide requisite crisis support, before enrollment.

All subjects completed the following standardized measures of distress:

- **VOCA Assessments: Baseline** – a self-report measure which helps clinician understand the individuals exposure to the death and the relationship with the deceased
- **Beck Depression Inventory (BDI)** – a self-report measure of clinical depression
- **Death Imagery Scale (DIS-R)** – a self-report measure of death related imagery (reenactment, rescue, revenge, reunion and remorse)
- **Complicated Grief Assessment (CGA)** – a self-report measure of death related trauma and separation distress
- **Impact of Events Scale - Revised (IES-R)** – a self-report measure of death related trauma
- **PCL-5 –** a self-report measure to measure post-traumatic stress disorder.

The same measures were repeated at the end of the intervention for comparative analysis.

Statistical Procedures and Results

Means and standard deviations were calculated for the assessed continuous measures (e.g., age, time from loss); frequency distributions were calculated for categorical measures (e.g., violent mode of death by homicide, suicide, accident).

T-tests were used to compare pre-post means for each psychological distress outcome measure (e.g., testing to reject the null hypothesis of no difference between baseline and follow-up means). Pearson correlation coefficients were used to determine factors significantly associated with the outcome distress measures. A repeated measures analysis of variance then modeled the effects of each factor found to be significantly bivariately associated with an outcome measure. Specifically, these models simultaneously estimated the effects of treatment group, psychiatric treatment history, witnessing the victim die, prior worry about the victim, attachment and dependence on the victim on each outcome summary score, adjusting for the within-subject effects of time (pre-post differences).

Results

The reader may review the specific outcome results in each of the studies cited in the reference list, but collectively the data describe the subjects as predominantly Caucasian (70%), female (70%), adults (45 years) who were well educated (60% college graduates), and reported a high frequency of previous mental health treatment (30%) and psychiatric diagnosis (25%). Nearly all (98%) were related to the deceased (30% parent of deceased child, 25% child of deceased parent, 15% sibling, 7% spouse, 13% other). The majority of the violent deaths were homicidal (70% homicide, 15% suicide, 15% accident).

The intervention began more than 6 months after the violent death. The interval between pre and post self-report measures was 3.6 months.

While there were minor variations in raw scores across studies, the mean scores of the BDI, DIS, CGA and RIES-R before intervention were significantly elevated, suggesting a high level of generalized distress that followed a highly significant ($p < 0.05$ to 0.0001) decrease on all measures of distress coincident with the intervention.

These pilot studies demonstrate that participation in an open trial of the Restorative Retelling intervention in highly distressed subjects within the first year of the violent death of a loved one is correlated with significant improvement on standardized measures of depression (BDI), death imagery (DIS), and trauma and separation distress (ITG and IES-R).

Intervention was marked by a high degree of engagement in participation (less than 20% of subjects dropped out of groups at either site), and there were no reported complications.

It would be misleading to disregard the spontaneous improvement these subjects might have realized within the same time interval (3.6 months) without intervention. A comparison of subjects randomly assigned to a different intervention or a non-intervention control group that might validate the effectiveness of RR awaits study; however, this report's documentation of improvement in highly distressed subjects should not be dismissed. It could be held that a highly distressed cohort would not show such robust improvement in so short a time without intervention.

The results of this pilot data reinforce the intuitive recognition of the power of the peer group as a matrix for stress reduction and supportive re-exposure for highly distressed family members after violent death. The study also demonstrates that time-limited and agenda-limited RR group therapies are replicable in other sites, well received by participants and not associated with high dropout rate.

*** UPDATE:**

In 2015, the new self-report measures utilized by this program are:

- **VOCA Assessments: Baseline** – a self-report measure which helps clinician understand the individuals exposure to the death and the relationship with the deceased
- **Beck Depression Inventory (BDI)** – a self-report measure of clinical depression
- **Death Imagery Scale (DIS-R)** – a self-report measure of death related imagery (reenactment, rescue, revenge, reunion and remorse)
- **Complicated Grief Assessment (CGA)** – a self-report measure of death related trauma and separation distress
- **The PROMIS Global Health Assessment –** a self-report measure to assess health-related quality of life.
- **PROMIS-29 Profile V2.0-** a self-report measure to assess mental health quality of life.
- **PCL-5 –** a self-report measure to measure post-traumatic stress disorder.

Copies of these standardized measures and their scoring are available upon request.

II. STRUCTURED INTERVIEW

It is crucial that the interviewer actively stabilizes the subject during the initial interview – before a detailed inquiry about the violent death. The initial goal of support includes the active reinforcement of resilience – enhancing skills of self-comforting, establishing a "boundary" or emotional distance from the reenactment and an active summoning of hopeful and vital imagery.

This is not the time for a diagnosis, or searching for past traumas and vulnerabilities. Someone highly distressed after a violent death needs clarification and direction during the initial session and questions should search for inner and outer resources of resilience and support.

Interview:

Previous history of trauma

- What helped you cope?

Previous history of death

- What helped you cope?

Resources of support

- Family, friends, work, church or spirituality – concept of death.

Co-morbidity

- Previous counseling, psychiatric treatment, medications, hospitalization
- Previous Psychiatric Diagnosis – Major Depressive Disorder, Post Traumatic Stress Disorder, Chemical Dependency, Anxiety Disorder, Obsessive Compulsive Disorder

Contraindications to Restorative Retelling Intervention

- Active drug or alcohol abuse
- Intellectual handicap with diminished memory functioning and affective control
- Active psychosis
- Incapacity for trust, disclosure, safety, control and hope

TRIAGE

Clinicians should reflect on the following:

- **Is the individual currently working with a mental health counselor?**
  Would you recommend that the individual consider this? Think about whether you feel the individual has characterologic traits that would make it difficult for him/her to work in a group, particularly a short-term group whose focus is on violent loss.
  Do you worry this person might not be able to modulate their feelings in the group, or will be overwhelmed with feelings of fear or sadness?
  Or do they perhaps need individual counseling before participating in the group in order to address serious problems and symptoms related to sexual abuse, domestic abuse, or a difficult marriage?
  If you have these concerns, rather than "reject" that individual for participation in the group, suggest the need for limits and the support which individual counseling can provide.
- **How is the individual sleeping? Eating? Focusing? Making decisions?**
  Are they able to meet school or work obligations? Socially isolating? Having panic attacks? Flashbacks? Nightmares? Auditory or visual hallucinations? Managing anger?
  Feeling hyper vigilant? Noticing an exaggerated startle response?
- **Has the individual sought an evaluation regarding medication?**
  We suggest this when someone reports panic attacks, disordered sleep, moderate to severe generalized anxiety, and/or clinical depression.
- **Does he/she have suicidal thoughts?**
  If so, follow up with a suicide risk assessment and consider whether group is the most appropriate treatment at this time.
- **In your assessment, do you have concerns that the individual has a character disorder, is semi-paranoid, narcissistic, avoidant or borderline, for example?**
  If so, think about the overall make-up of your group. Before you decide to take this individual into the group, make sure you don't have others with similar difficulties.

What makes borderline or narcissistic individuals difficult to work with in a group are manipulative traits, demands to be center stage, unempathic responses, difficulty in perceiving and valuing others' points of view and impulsivity. Take into consideration the effects this individual might have on your group (and on you).

III. INTRODUCTION TO RESTORATIVE RETELLING GROUPS

Restorative Retelling is an intervention that is specific for adults unable to accommodate to the unnatural dying of a close friend or family member because of prolonged (greater than 4 months) symptoms of intense trauma distress (reenactment imagery, avoidance, hyper arousal) and separation distress (pining, emptiness, self-disintegration).

Restorative Retelling uses a time-limited group format. The support group model offers a context of immediacy and mutuality because of the commonality of the members' experience from an unnatural death from homicide, suicide, accident, terrorist or combatant attack. Gathering individuals who share distress to a similar event is a potent restorative catalyst. As the support group model has shown, the simple maneuver of encouraging disclosure and support in such a homogeneous gathering is in itself helpful in the absence of clinical techniques specific to a theory or format. Presumably the support of other group members reinforces the nonspecific helpful elements of trust, safety, coherence, and hope and control for change. Thus, another primary but nonspecific task of Restorative Retelling will be the initiation and reinforcement of group cohesion.

Specification of Active Ingredients

- Psychological resilience (the capacity for self-soothing and capacity for maintaining detachment, i.e., not merging with a traumatic image) is reinforced during the initial sessions. This reinforcement of resilience is a requisite process upon which subsequent imaginal modification will occur. Without resilience, the approaching imaginal exposure will provoke unbearable distress and compensatory avoidance.
- Restoration of positive, non-traumatic imagery of the deceased and self is actively initiated through "reunion" sessions serving as a positive counterbalance to the intrusive imagery of self and the deceased, which commonly takes precedence and is associated with the dying. Re-establishment of antecedent imagery also fosters a firmer basis for establishing and maintaining detachment.

- Once resilience (self-calming and detachment) and antecedent identities of autonomy are clarified and practiced, Restorative Retelling introduces direct imaginal exposure of death imagery through directed drawing; i.e., the client draws imagery of the unnatural dying and presents the drawing for processing with the group.

Prohibited Interventions

- We do not find psychological concepts that demand unconscious determinants or remarks that diminish hope for improvement, alone or in combination, to be helpful.
- Premature exposure to overwhelming imagery will be met with avoidance and premature termination.
- Insistence upon abreaction (of crying, anger, or terror). Avoidance and stoicism serve a purpose and should not be prematurely challenged.

Goals and Goal Setting

Indications for Restorative Retelling death from unnatural dying (terrorism, combat, homicide, suicide, accident) four months or more before consultation have led to clinical dysfunction with heightened separation and trauma distress, death imagery, possible clinical depression, significant impairment in daily functioning, avoidance, hyper arousal, and/or intrusive thoughts indicative of post-traumatic stress disorder.

Restorative Retelling will not complicate or be complicated by other interventions. It is common for group members to be taking psychotropic medications for co-morbid depression or anxiety disorders. The assessment for psychiatric medication support and its management may be independent of RR since it requires psychiatric consultation and long-term maintenance. Group members may also engage in other modes of psychological support without dissonance because of the specificity of our focus and purpose. Obviously it is advantageous to confer with the outside facilitator or therapist to ensure coordination and mutuality in treatment focus.

Our time-limited format does not encourage consideration of personal or interpersonal dysfunction beyond the relationship with the deceased and previous experiences of separation and trauma. Couples are cautioned that RR will not deal with communication problems antecedent to the unnatural death. In this setting, responses to the criminal/judicial/penal institutions are also not encouraged.

The RR group focus is on unresolved responses to unnatural death and the agenda contains a specific staging of techniques to modify images of trauma distress and separation distress. To our knowledge, the combination of stress management and structural imaginal exercises in a staged group format for complicated grief after violent death is unique to Restorative Retelling.

Preparation/Pre-Screening

Individuals requesting Restorative Retelling are assessed by the clinician with a semi-structured interview and screened for co-morbid disorders. Prospective group members are given a series of self-administered screening assessments which, measure depression; post-traumatic stress disorder; complicated grief and the presence of traumatic death imagery. These screening assessments are repeated post-treatment to document change.

Prospective group members are asked if they have participated in a group before. This is a good opportunity to assess and discuss positive and negative group experiences.

There are times when couples or other family members want to participate in the same group. It is important during the screening session to observe their interaction and assess if they are able to share their grief, thoughts, feelings and emotions openly.

During this meeting an agreement is reached to focus on the imagery of trauma and separation. We contract to meet for 10 weekly two-hour sessions and review a handout of the week-to-week agenda so each member has a clear and concise expectation of our format. Group members are provided with an agenda and a copy of Dr. Rynearson's paper "Accommodation to Unnatural Death".

Session Format

Typically, the group has two facilitators and no more than ten members. We orient individuals in the initial appointment. RR begins with a clear expectation of proximal termination. It is explained that the group is a closed, time-limited group which, meets weekly for a two-hour session, beginning and ending on time for ten consecutive weeks.

We inform the group members of the importance of attending all sessions and if they are unable to attend, the importance of calling in and sharing the reason for absence with facilitators' and other the group members. This is particularly important because members struggle with issues of unpredictability, sudden loss, anxiety, rejection and abandonment.

Structure of the Sessions

We call attention to the number of sessions remaining and the focus of the present session. There is a topic and an agenda for each session. As the sessions progress the group members take a more active role and the sessions become less and less facilitator directed. We all need to remain open to what unfolds. The work is in following the process as it leads through the main points.

It is helpful to open the session with a short grounding/breathing exercise ~ deep inhale and exhale. Group members have shared that this pause allows them to take a deep breath, let go of their day and focus on the group.

This is followed by a brief (5-minutes or less) individual "check in" for each member. Members are encouraged to focus on thoughts, feelings and images related to the memory of their friend or family member who was killed and what change or changes have occurred in those specific thoughts or images in the past week.

Beginning each group with this brief "check in" maintains a specific focus and allows a monitoring of change in traumatic imagery in all members, including members who might be so shy and avoidant that they could resist divulging themselves spontaneously.

This check in also allows for a brief update on feelings related to home assignments or others issues participants may want to share with the group (i.e.: court update, birthday and other celebratory events).

The check-in of death-related thoughts and imagery is followed by a brief didactic or cognitive piece. For example, the facilitator may talk about how traumatic loss differs from separation loss; what PTSD is; what co-morbidity is; or what death imagery is, and why it often occurs following a traumatic loss.

Sequence of the Sessions

Placing the reunion sessions after the initial four sessions and before the death imagery sessions is a carefully designed aspect of the treatment. The reunion sessions give each group member an opportunity to focus on positive aspects of who the deceased person was before the trauma occurred.
These "presentations" may also help each member gain perspective in terms of time and actual events surrounding the death. Additionally, getting to know more specifically about each person who has died, group members also share each other's losses to some degree. The feeling that the group "knows" the loved one, even slightly, seems to provide relief to the group member. The group cares. The group knows the person who died was special. The group feels the loss. The group is no longer made up of strangers.

Each session ends with a 5-10 minute guided imagery experience. We have planned a series, beginning with anchoring and breathing, that teaches the basics of progressive relaxation. Often what occurs in the sessions suggests content for guided imagery extensions of the relaxation. Sometimes we use pre-planned images. In addition to teaching and encouraging practice with self-soothing techniques, ending sessions in this way gives members a chance to quiet themselves before leaving the group.

Documentation:

Chart notes on each participant after each group session.

Group Assignments

There are four assignments members are asked to do for group.

- Reunion presentation is prepared by each member
- Drawing death imagery
- Family and Friends Session
- Resilience drawing

RESTORATIVE RETELLING GROUP OUTLINE

GROUP ONE

1. **ORGANIZATIONAL:**
    - Have name badges/tags until the group is comfortable remembering everyone's name.
    - This is Session #1 of ten, beginning today and continuing through (date)
    - Parking/restroom
    - Where to "assemble" before group
    - CONFIDENTIALITY (includes who is in the group, death of loved one, issues/problems and what happens in the group)
    - Importance of 10-week commitment
    - Let us know if you're not coming by calling the office prior to group.
    - If group sessions are videotaped; or sessions used for teaching or research purposes, have all members sign releases. (It is important that each member be notified during the individual interview; this should come as no surprise).
    - Collect self-administered screening battery from each member.

2. **INTRODUCTIONS:**
    - Facilitators
    - Group members: Name, loved one's name, relationship and type of death (homicide, suicide, etc.) no stories just introductions.
    - Feelings check- (Facilitators will explain weekly check-in and purpose)

3. PURPOSE OF THE GROUP:

- To deal with the traumatic loss(es) in more active ways
- To foster resilience
- To improve overall health and daily functioning
- To learn how to pacify and calm yourself
- To separate your self from what happened
- To restore a sense of having a future
- To learn from and support each other in this process.

NOTE: Reassure the group that no member will be put "on the hot seat." Acknowledge avoidance and resistance -- that members would probably rather not attend this particular kind of group at all with its focus on traumatic loss.
In participating in RESTORATIVE RETELLING, they will think and probably talk about things they would never have chosen to think or talk about before the death.

4. CONTENT:

How sudden un-anticipated violent death differs in its effects from the effects experienced after the anticipated death of family/friend.

- No goodbye; no resolution
- No time to adjust or make preparations
- Problem to understand/accept/process the sudden way they died
- If violence was involved...
- Violation of the person who died; violation of you (no choice)
- If the death was "willful" (e.g. suicide), what that person "did" to you
- No choice

NOTE: It is important to normalize symptoms in this session and explain the associations with sudden violent death. The point is not to make members' symptoms "OK", rather it is to explain and recognize the existence of co-morbidity at this stage in all members of the group.
Comments by facilitators such as "of course" and questions asked in a matter-of-fact tone foster members' disclosure of difficulties in functioning.

5. THE NARRATIVES:

Death Notification:

A good question to ask prior to sharing the story is: "Tell us how were you notified of your loved ones death?"

Sharing the story:

When and how did their love one die? "Tell us what happened".

NOTE: Members need reassurance that narrating what happened is a very difficult thing to do as well as listening to each other's stories.

6. GROUP MEMBERS' RESPONSES TO EACH OTHER:

Facilitators might ask the group after they have shared their stories:

"How was it for you to talk about/to hear about what happened?"

"Does anyone want to add to what was said?

Facilitators, somewhat familiar with each member's history from the initial interview, should be aware of possible connections that may create early group interaction and cohesion.

The following are some examples of connections facilitators know or learn about during the narratives which can be useful for upcoming sessions

Who has children living at home?

Who has no living children?

Who is working? Who is not working?

Who has feelings of guilt?

Who is having a difficult time in their relationships with their partners?

Who sees many superficialities in their world?

Who questions whether there is anything meaningful in their lives since the loss?

ACKNOWLEDGE SIGNIFICANT DATES

Check with the group to identify any significant dates occurring during the remaining sessions. This includes anniversaries, birthdays, anniversaries of death, and any other special dates.

Note/write down these dates and remember to acknowledge them as part of the group.

RELAXATION EXERCISE (See "Relaxation Techniques".)

GROUP TWO: SOURCES OF SUPPORT

Check-In:

Handout: "A Feelings Repertoire" - Consider the "Feelings Repertoire" as you check in today. You might use 2-3 feelings from the list as we go around.

NOTE: After the experience of losing someone you love in a sudden unanticipated way, you may have little sense that you "feel" anything at all or that you only feel "bad" or "OK." The range of feelings for you have shrunk to nothing. Or you may feel something, but much less intensely. Occasionally your feelings may explode inside/outside you. Or you may only be aware of feeling "bad" feelings.

1. CONTENT: *Current sources of support:* family, friends, community, work, faith or spiritual beliefs. It's important to feel supported, that you have someone or something to fall back on. All of us need this, the sense of some person being there. Have you become isolated? Do you ever feel although you are surrounded by people, you don't belong and, you're not supported? Perhaps here in the group you will begin to feel connection, a matrix of belonging.

- Who has been supportive to you? How so?
- Have your supports changed since the loss?
- Do you think you have "worn out" all your sources of support?
- What support could be available now?
- Do you protect those closest to you, hiding how you really feel or pretending to feel one way when you feel another?
- Who/what does not feel good/safe for you to be around?
- Do you ever feel that "nobody can ever understand?"

Religious/Spiritual: What about your religious/spiritual community, beliefs or practices? Do they sustain you? What concept of death does each of you have? Do you have a concept of there being an after life? Do you sense a promise of reunion with the person you lost? Do you ever consider death to be a release for that person? Has this changed? Question of meaning: Why?

2. RELAXATION EXERCISE

GROUP THREE: **CHANGES/PREVAILING**

Check-in:

Handout: "How Have You Changed?" People sometimes say they've changed in all the ways in the handout. (See handout in appendix.)

NOTE: By this session, often the traumatic losses that brought people into the group **resonate** with other previous losses (e.g., the death of a grandmother; a dog/cat; a sibling; a miscarriage/abortion). This may be shared by members and/or brought up by the facilitators.

1. CONTENT:

- How have you changed since the loss? (Consider physical, emotional, spiritual changes.)
- Possible changes include health, work, creativity, finances, nutrition, exercise, routines, sleep, friends, future, family relationships, sense of pleasure.
- How have you been dealing with these changes? Who has been most affected by these changes in you? How have you been dealing with these changes with these others?
- What about self-care? Do you do things for yourself? Are you paying attention to your needs and feelings? Do you engage in activities that you enjoy and find relaxing? Exercise regularly?

Prevailing does not mean "getting over" or "forgetting" or living "as if" this never happened or "denying" what happened. It means integrating what has happened as much as possible, living with it, functioning in your daily lives, feeling some connectedness, some purpose.

This traumatic event has changed you. You won't at some point, when you're "better," go back to being the same way you were before. This loss is part of your journey. Now you have choices to make, maybe choices you wouldn't have been faced with if it hadn't been for this loss. Some people need to move out of a house; some find they can't go back to the same jobs; maybe there's a partner in your life and you need to at least question how that relationship feels to you now. Some of the old ways don't work and you seek new ones.

2. RELAXATION EXERCISE

GROUP FOUR: CO-MORBIDITY

Check-in:

Check with the group regarding any self-care activity they resumed or participated in since the last session.

1. CONTENT:

- What is "co-morbidity"? Prevalence of ***DISEASE*** or ***ILLNESS*** or ***ILL HEALTH*** that often goes along with "bereavement". This may include accidents.
- ***Depression*** (lack of concentration or focus, inability to make decisions, feelings of worthlessness, hopelessness, loss of identity, social isolation, weight loss or gain, psychomotor agitation or retardation, suicidal ideation or attempt, restricted range of emotions, sleep problems, no pleasure, no meaning).
- What are ***some Post-Traumatic Stress symptoms people might experience***? (Panic attacks, flashbacks, re-enactment, active avoidance of reminders, terror, nightmares, intrusive thoughts).
- This session allows for discussion of other feelings such as ***REVENGE*** for the loss (particularly related to homicide), ***SELF-BLAME*** for what happened (if only I'd...) and, most commonly

  RE-ENACTMENT what you imagine the person heard, saw, felt (pain, suffering, terror) and what happened during the last moments of their life.
- Change in or disappearance of ***sexual feelings***, perhaps the disappearance of this in an ongoing significant relationship. "I look in the mirror and all I see is a middle-aged woman," one group member said, "my husband moved upstairs last week". " I can't find pleasure in intimacy, I don't want to feel pleasure… but for my partner they say, they need this closeness"
- ***Substance abuse "What is it like to have one drink too many?"***

The feeling of being ***FROZEN*** since the loss is also significant. Everything has been on hold, often for years. Perhaps people in the group can identify what they feel they need to do, specifically and/or generally (e.g., sell a house; divide family treasures among family members; end a relationship), but they have been unable to take steps towards doing it. They don't know where they're going, and don't even see a bridge.
This is also related to feelings of guilt, which lead to feeling unworthy. If someone feels unworthy, they believe they don't deserve to feel better, to move on, to walk into any future, to create a home, to start something new, to laugh, to love and be loved, to hope.

Group members often report feeling invisible, going through their days on the outside, observing everything and everyone without a sense of belonging or relating. They no longer communicate, no longer seem to care about anything. They are not interested in chatter and become irritated when they hear others complain about trivial issues. They may "look good" or "like everyone else," but they are not "seen." They may not WANT to be "seen."

It may be helpful to discuss cultural traditions of grief and loss and how such significant losses are honored. Where do our group members do this? With whom?

NOTE: It is easy and tempting for facilitators to want to give advice. Members by this session may say they came to the group wanting and expecting to get answers: how to get over the intense symptoms of grief; how to get over self-blame; to learn specific methods and tools or to be given assignments to stop feeling miserable and stuck. If <u>you</u> feel someone is telling you, you aren't doing enough, aren't saying the right things, and are not meeting their needs, pay attention. Get consultation. In RR it is critical to stay with the GROUP process. If someone in the group needs more, perhaps they need referral to individual treatment. Perhaps the <u>group</u> has this feeling. Sort it out. By now, you can use the group for this process.

2. ORIENTATION TO REUNION/NARRATIVES

In order for the group to know more about the person you lost, we'll spend the next two sessions with reunion/celebratory narratives, where you introduce your loved one. You may bring in photographs, objects, videotapes, or choose other ways to share memories with us. You can be as organized as feels comfortable for you. We would just like to know more about the special person you lost.

As a group, you can choose when you would like to present. Depending on the size of the group, plan to spend approximately 20 minutes each.

3. RELAXATION EXERCISE

GROUP FIVE: REUNION

Check-In: This check-in will include a brief discussion of feelings, reactions while preparing for the reunion presentation.

1. REUNION PRESENTATIONS

NOTE: These presentations vary widely in the degree to which each member has organized their time. For example, a member may bring a manila envelope, long unopened, containing news clippings related to the loss, which the member then reads in no particular order and passes around the group.

In contrast, presentations may center on printed collections of writings and sketches produced by the deceased with copies for each group member. We have eaten favorite foods; viewed videotapes; listened to musical recordings; shared accounts by an artist whose professional art pieces were based on memories of the deceased and of the nature of the loss. What is important is giving the group a feeling for the unique and special qualities of the deceased and of the nature of the group member's relationship with that person.

Members sometimes discover they haven't experienced positive memories of the deceased in quite some time, especially in the case of suicidal loss or family violence. Preparing for these presentations has helped members repair their sense of perspective. Sometimes members say they haven't thought about or looked at special item's belonging to the deceased because of the pain it caused. Group members may realize they've lost a sense of time or the order of events surrounding the loss. Preparing for the group helps them identify these "blurs" and allows them to sort through them.

2. GROUP RESPONSES "What was it like for you to share today? What about seeing the other presentations?"

3. RELAXATION EXERCISE

GROUP SIX: REUNION

Check-in:

1. REUNION PRESENTATIONS continued

2. GROUP RESPONSES

3. ORIENTATION TO DEATH IMAGERY

NOTE: You may orient group members in a way similar to the following:
*"Many times people feel they have these images **inside** and sometimes they are also fearful of their real feelings if they think about the images. In sharing your drawings, you won't be alone with the imagery any more. In getting what's been inside you **outside** you through the drawings, what you've seen or imagined so many times will become more real in the sense that you will be putting these into words. Then we can all share some of what you've been carrying alone."*

Death imagery, coming in Sessions 7 and 8, is counter-balanced by the Reunion imagery of Sessions 5 and 6. The violation, victimization, violence, helplessness and terror members often feel when remembering, drawing and presenting death imagery does not stand-alone. Preceded by the reunion imagery, individual members as well as the group as a whole are much more likely to hold images of the deceased and relate to rather than partition off the death imagery. Members may "reframe" rather than "avoid" these intrusive, repetitive, re-traumatizing scenes.

At times group members will feel safer and prefer to draw their image in-group or in your office prior to group meeting. It is important to be open and flexible. If the group prefers to draw imagery in the group setting, you will need to set an allotted time limited of 20-30 minutes for completion and then proceed with presentations.

Facilitators may ask the group if they are willing to stay a little longer during session seven so the majority of the death imagery exercises are completed in one session.
Session eight would include remaining exercises and additional time to further discuss and consolidate their “reframed” dying reenactment narratives.

4. RELAXATION EXERCISE

FACILITATOR PREPARATION FOR: GROUP SEVEN: DEATH IMAGERY

As a facilitator, this may be one of the most difficult sessions to address in group.
The thought of asking the group to draw the death images and revisit such a painful time may seem daunting and counterproductive. You may question the rationale especially after the reunion presentations. The group at this stage has been going well and you may have even noticed light moments of laughter or other significant and positive changes.

It is important to remember that although group members are not talking about the images they may be thinking about them. This is one topic they may actively avoid. It is a topic usually not shared with anyone - a topic others do not want to hear. Couples or other family members in the same group have expressed surprise when images are shared because they were unaware of the other family member's thoughts or images.

The group is a safe place where only those who have experienced these types of losses can relate to the reenactment thoughts and not be frightened nor judged. The worst has already happened the day their loved one died and, this exercise allows them to share these reenactment images.

Once you become confident in this process as a facilitator, you can provide a safe encouraging environment for group members to participate in this activity. Facilitators are encouraged to play some soft relaxing music and allow the group members the time and space to complete exercise.

The images that group members have may vary. These images are not always of the dying but of other intrusive thoughts surrounding their loved one's death.

The following interactive description between therapist and group member is an illustration of a Death Imagery session.

Reenactment Exercise:

Since reenactment is primarily based upon the imaginary visualization of the violent dying actions we encourage the pencil and crayon drawing of the imagined imagery,

> **"Even though you weren't there, you probably have an imaginary replay of the dying in your mind – and more in pictures than words – we want you to make a drawing or a series of drawings which shows us what you are seeing in the replay."**

When completed the drawing serves as an externalized and shared image for mutual retelling – often the first time the patient has "put words" to the horrifying visual reenactment. While most patients cooperate in completing this projective exercise, some patients (and some clinicians) are more comfortable with the stark verbalization of the reenactment imagery. In any case, it is important to offer the patient alternatives in sharing the reenactment so any number of materials may be considered:

- Drawing the reenactment imagery
- Telling the reenactment story
- Writing the reenactment story
- Reading police/newspaper reports of reenactments and watching TV video reports

Reenactment prologue:

Cast of Characters:

Setting: The "introductory phase" and reunion retelling between the players has been completed and prepares them for the retelling. The patient agrees to complete a pencil and crayon drawing of the death scene for the retelling (or may wait until the session and complete the drawing with the support of the therapist).

Patient: Pat, "a traumatized, remorseful young mother merged in the reenactment of her murdered child."

Deceased: Paul

Therapist: and "Moderator"

Script:

Therapist: "**Before we begin – how was it to draw out the death imagery?"**

(It is important to gauge the patient's anticipatory reaction to the reenactment – and to support the patient who feels excessively apprehensive).

"How would Paul feel about your presentation?"

(The answer may reflect the patient's projective judgment – that Paul might approve or disapprove – and, accordingly, serve as willing or unwilling collaborator).

Patient: (Says that it was very difficult for her to make the drawing, she dreads talking about it, but Paul would approve of her sharing it with others).

Pat holds the picture against her chest beneath crossed arms – as if she won't allow anyone to see what she has only imagined – and by its revealing what has been private and surreal is about to become real.

Now she holds the drawing before her and begins crying as she points to the image of Paul in the center, the only human figure.

The drawing does not contain Pat – she is nowhere to be seen.

(The absence of the adult patient in reenactment drawings is the norm – corresponding to their absence during the dying – by contrast, child patients often include others in dying imagery drawings playing an imaginary role of intercession and rescue)

Paul, her 12 year old son, lies in the middle of a sidewalk gunned downed in a drive-by shooting as he was walking to school. The drawing graphically reveals his bleeding head wound bathed in red and the car speeding away with the murderer's gun protruding from the window. They were never apprehended.

Pat then describes how she was notified of the murder – by the police who described the shooting and drove her to the hospital where the emergency room staff announced Paul had died at the scene of the killing.

She then points at the blue sky and clouds and places Paul's angelic spirit as being released above the dying scene.

Pat sobs and rocks herself and her drawing – again grasping it against her chest with folded arms.

Therapist:

> **"I am so sorry, Pat - and not only because your drawing is filled with such tragedy – but because you have had to tell this story to yourself over and over again without anyone sharing it with you. How does it feel as you begin to release it and let someone else become a part of the telling?"**

(Invariably the patient feels some relief in sharing the narrative with someone prepared to empathize and soften the isolation within the anti-narrative).

> **"Let's look at the drawing together – I see Paul, but you aren't anywhere in the drawing – and I understand that because you weren't there when he was dying – but let's try to find a place for you in the drawing of this story – where would you want to put yourself and what would you want to do?"**

(Pat places herself on the sidewalk with Paul)

Therapist:

> **"All right, now that you have placed yourself beside Paul let's imagine what you would have done?"**

(Initially Pat wants to keep Paul from going to school, then tries to keep the shooting from occurring by somehow stopping the car – preventive and forceful enactments to reverse the action of the story – then with the guidance of the therapist allows herself to assume a role within the dying scene, holding Paul as she feels his spirit receding to transcend into the clouds and sunshine and finally cries as she gives Paul a final kiss and releases her embrace).

Therapist:

> **"If he had died from a natural cause you would have had time to have done all of those things with Paul."**

Prepared to follow any number of Pat's imaginary enactments (including rescue, respect, caregiving, relinquishment) the therapist guides the retelling from one imaginary enactment to the next. These compensatory enactments of rescue, resuscitation and reunion are iconic, preverbal acts – once introduced they maintain themselves. They are "natural" enactments of a natural dying eclipsed by the ascendency and intensity of reenactment imagery of violent dying, and once triggered lend coherence and vitality to counterbalance the reenactment themes of nihilism and despair. They are familiar and comfortable enactments that flow spontaneously and naturally from Pat as Paul's mother.

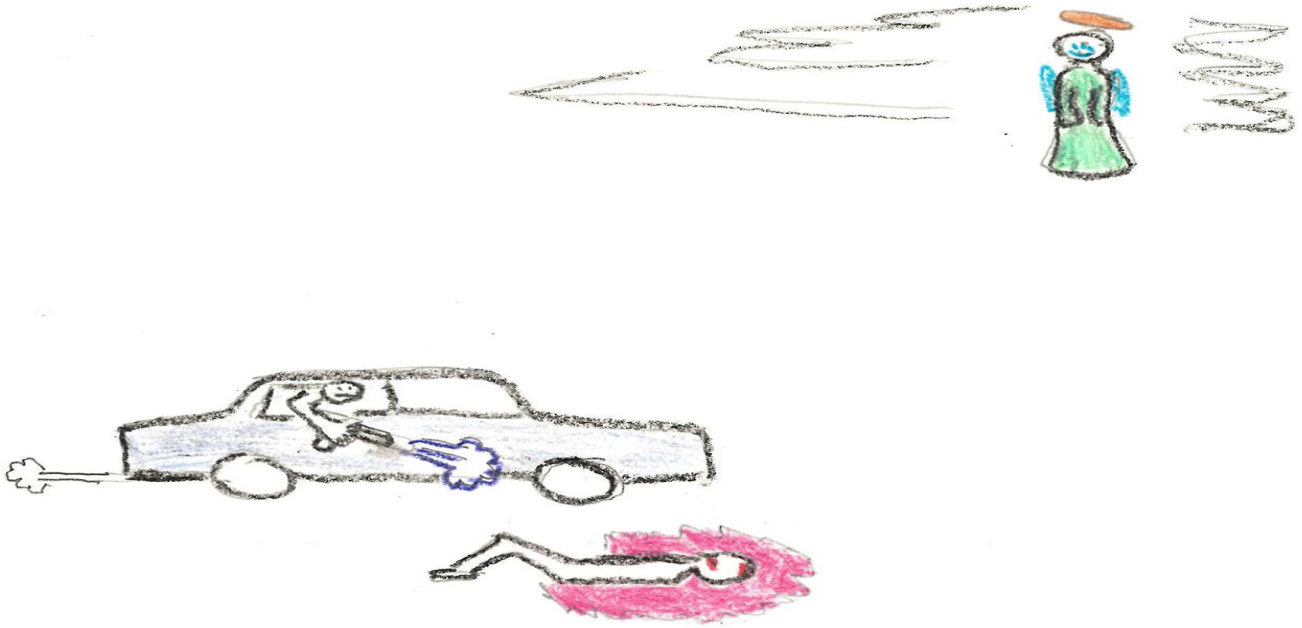
The restorative goals of the reenactment exercise are to initiate the enactment of care giving and care seeking by placing Pat in the imagery with Paul, and to engender preservation (the initiation of Pat's linking enactments of rescue, reunion and resuscitation) through action based suggestions – but Pat's release from the double binding entanglement and Paul's role reversal (now serving as care giver for Pat's remorse) may be potentiated by imaginary, triadic communications between therapist, Pat and Paul.

Therapist:

> **"You seemed to be trapped in the story of Paul's dying – perhaps because of your ultimate obligation as Paul's mother and protector you couldn't allow this violent dying to happen - somehow you should have prevented it - and now you have to remain with him in the story so he won't die all alone. How would Paul feel about your imprisonment in his dying story? What could Paul do or say to help release you?"**

(The "double binding" attachment is so remorseful and aversive that Pat cannot abandon Paul or create a role for herself in the reenactment story, but perhaps Paul and the therapist can guide a retelling that will restore her role as care giver. Paul might remind her of what a conscientious and caring mother she had been, that he didn't believe she was responsible for his dying, that she would have sacrificed herself to save him --- but she needs to continue to take care of his younger brother and sister and his father. The therapist might suggest that Pat and Paul comfort one another as they cry and reassure each other they will remain safe and whole as they release themselves from the dying story. Like Pat, Paul needs to find a role for himself beyond the dying narrative so his spirit is at peace. Like restorative retelling, the revision of Pat's role in the attachment narrative is a mutual task – all three voices introducing harmonizing themes encouraging Pat and Paul's movement out of and beyond the fixation – and the changes are concessionary rather than welcomed.)

Death Imagery Illustration



GROUP SEVEN: DEATH IMAGERY

Check-in:

NOTE: It's important to remind members that this is the seventh group session of ten.

1. DEATH IMAGERY

- Hand out several sheets of drawing paper to each member along with a selection of pencils, pens, crayons or markers for them to choose from for this exercise.
- What do you imagine or see repetitively, in dreams or in waking moments?
- At times, maybe several times every day and night since you experienced the loss, maybe you've imagined what the last moments were like for the one you loved. What do you see happening? What do you hear? Who was there? Where was it? Where were you? When/what time of day? What do you play over and over in your mind about that time?
- Take these pieces of paper. Draw what you imagine. Again, we'll share this imagery over the next two sessions.

Tell us about your drawing. What do you imagine the person's last feelings and thoughts were? Tell us what happened? Where do you imagine yourself, if you'd been there at the time of death? What do you imagine yourself doing, if you'd been there?

Facilitators can often support members in their presentations by encouraging members to begin a dialogue with the deceased. For example, facilitators may ask, "If the person were here with us, how would he/she want you to remember them?" or "How would they help us get through this imagery?" or "How could they help us with this support?"

2. MEMBERS' RESPONSES

3. RELAXATION EXERCISE

GROUP EIGHT: DEATH IMAGERY DISCUSSION/OPEN GROUP

Check-in:

1. **DEATH IMAGERY continued discussion**

This session allows participants to further discuss thoughts, feelings and emotions associated to the death imagery exercise.

Questions:
"Now that a week has passed since you drew your images and share them with the group, what changes have you experienced with regards to your images?

During the past 8 weeks, we have covered many topics is there anything left unsaid? Is there topic you would like to more discussion on?
Lots of times folks want to talk more about feelings of anger? Guilt?

2. MEMBERS' RESPONSES

3. PREPARE FOR THE FAMILY/FRIEND SESSION

Next week you'll be bringing a family member or a friend who's played an important part in your life. We would like to welcome them and include them. We'll ask you to introduce them and tell us how they've been sources of support for you. We'll ask them to describe changes they've seen in you, ways you've been sources of support for them and to share in their concerns.
We will develop a ceremony together.

4. RELAXATION EXERCISE

GROUP NINE: FAMILY/FRIENDS

Check-in:

1. INTRODUCTIONS

To the group member, please introduce your family member and/or friend. How has this person played a supportive role for you?

2. FAMILY/FRIEND

***Questions for the invited guest*:**

What changes have you seen in (group member) since the loss? Since (group member) has been coming to group? What concerns do you have about your friend/family (group member)?
What was it like for you to be invited here today?

Questions for the group member:

How has your friend/family (invited guest) been helpful to you since the loss?
Have you noticed changes in your friend/family (guest) since the loss?
Have you had concerns about your friend/family (guest)?

3. RELAXATION EXERCISE/CEREMONIAL RITUAL or CEREMONIAL ACTIONS

Note: The relaxation exercise for this session is replaced with a ceremonial ritual.

The goals of the ritual are:
(1) To acknowledge the loss the group member has shared with the friend/family;
(2) To thank each other for the support and acknowledge the support of the group
(3) To confirm the mutually supportive nature of the continuing relationship.
Some examples may include:

- Holding hands in a circle
- Moment of silence
- Saying "A Word" (Peace, Sharing, Love, Courage)

Facilitators may want to bring snacks (with less funding we cut a lot of costs of buying extras.

GROUP TEN: CONCLUSION

Check-in: How did it feel for you to have (your friend/family member) here last time?

RESILIENCE DRAWING:

Materials you will need: Drawing paper, pens, color markers, crayons

Activity 1: Have the group members draw the people, pets, places or things they feel a deep connection with; gives them joy, solace, peace, meaning – nurtures their soul and lifts their spirit Allow for 15 minutes to complete drawing. Then ask each group member to share their drawing. This exercise serves as tool for them to acknowledge, reconnect or embrace what has helped them in their life.

Activity 2: Group members and facilitators write a parting thought to each other about what touched them about that person and share their thoughts and meaning for their words.

2. POST INTERVENTION MEASURES: Group members are asked to repeat the same standardized measures they completed before the intervention for us to provide an objective comparison of their distress scores. The group leader explains that a private report of each group member's comparative scores will be prepared and invites the group to reconvene in one month to review.

3. **SCHEDULE ONE MONTH GROUP REUNION** (date, time, location)

4. **GOOD-BYES**: The following are some examples for the closing ritual:

Group hand-hug: One person begins by squeezing the hand of the person beside them. This person squeezes the hand of the next person and so on, until the "hug" has been passed all around the circle and comes back to the beginner who starts the hand hug going the opposite direction until it comes full circle.

GROUP ELEVEN: REUNION/ONE MONTH AFTER INTERVENTION

Purpose: To review and explain the results of the pre/post measures as a group exercise while each member reviews their privately recorded comparison scores.

Check In: Update or changes post group

IV. RELAXATION TECHNIQUES

The facilitators guide the group towards "connected awareness". Know that your voice is an important connection for members who are new to working in this way and/or new to working with you as a guide. Give them time to focus on their breathing, and relax on their own during this period of stillness, with you as their guide. They will become confident in you, in themselves, in the group. Your voice is a connector. Speak at a comfortable volume but be sure all can hear you. It produces anxiety in someone who is straining to hear what you're saying. Ground yourself in your practice so you can guide others.

Share with the group that in learning progressive relaxation, they may find themselves going to sleep. Sometimes this is an important and sought after outcome; but when using relaxation for self-soothing or centering, they will need to focus on one thing – their own breath.
Gently maintain awareness.

Benefits from practicing relation techniques:

- Relax: your mind (intrusive thoughts, images); your body (rapid heartbeat, stomach-digestive problems, dizziness, panic, headaches, blood pressure, infections, e.g. sinus, colds, flu)
- Positive physiological effects
- Calming
- Way to ground yourself after upset/difficult time or when you feel anxiety or disconnection

Reinforce and practice anchoring, soft belly, focus on the breathing, grounding your feet on the floor, the Earth.

Whether any of this is old or new for people, it is always good to practice.

- Hands over your belly can comfort you when you feel anxious or vulnerable.
- Hands over your heart can warm you to feel compassion.
- Anchor--thumb and forefinger; rest hands in lap
- Sit comfortably; nothing crossed; feel where you're tight blocked
- Close eyes if you're comfortable doing so
- If people, thoughts, pressures, negative voices--acknowledge: "later"
- Focus on breathing

Color Imagery:

At times, it may be difficult to relax the mind and free the thoughts. A simple exercise may facilitate the process. Have everyone pick a color that is soothing for them and a color they typically do not like or is not calming. With their eyes closed, body relaxed have them imagine that the soothing color floating through their body every time they inhale, and the other color which is negative exhaled. With each breath their body fills with this beautiful soothing color as they also exhale the negative color/energy.

As facilitators, you may already know of other useful relaxation techniques you can share with the group at the end of each session. For individuals to be able to learn how to calm themselves is empowering.

V. FACILITATOR ROLES

As in any group, the facilitators act as role models who set boundaries (time, space, order), put words to actions, thoughts and feelings, models nurturing and caring behaviors, and encourages connections and interactions among group members. Group members often view the facilitators not only as an authority but, as professionals with obligations to perform in certain ways in the group. They count on this. But this has its limitations and, in fact, as the group coheres and becomes more active, the role of the facilitators changes and becomes more of being present, holding, "getting out of the way" of the group.

The facilitators model acceptance, not judging members, not giving advice. The facilitators value feelings, which are honestly expressed. Distress or anger, sadness or confusion is made safe within the group as the facilitators maintain the healing setting and the relationships "under fire". Active listening, restating, soliciting input from the group are all important behaviors which aid individuals and the group in developing trust and resilience.

Questions and interpretations remain open-ended and tentative, since each member will discover their own distinctive pathway toward accommodation. The facilitators are not authorities with unitary solutions, but guides who help in establishing coordinates and boundaries. By maintaining group morale while inculcating resilient capacities as a counterbalancing referent to separation and trauma distress, the facilitators reestablish movement and direction beyond the unnatural death.

Since treatment is time limited, a strong and confident assumption comes from the facilitators that the group member can make this transition. Treatment goals are limited to beginning adjustment to unnatural death and to creating a solid basis for future accommodation. This emphasis on accommodation as a life-long challenge rather than a short-term cure is important to emphasize. In doing so, facilitators clarify their role as collaborative and catalytic instead of primary and sustained.

Essential in time-limited RR is the facilitator’s skill at assessing co-morbidity based on the screening battery and making decisions regarding the levels of adjunctive or subsequent intervention appropriate for each group member.

Complications in this short-term support relationship may occur as members become threatened by pressure for disclosure (safety), insufficient resilience (increasing distress) and personalized despair (no hope for change).

Sometimes these complications are related to pre-morbid characterologic traits or disorders. Clients with borderline, histrionic, narcissistic or paranoid vulnerabilities become angry, distrustful, and demanding of excessive time and attention. Careful screening for these traits prior to RR will avoid this complication. If knowingly, such an individual is included in the group, the facilitators should encourage and sometimes insist on individual support outside of the RR format. Complications can be addressed and answered by other group members as well as the facilitator.

Again, it is difficult for a time-limited group to support more than one such member. The facilitators have ultimate control over maintaining the helpful vector and occasionally must work on an alternative support for a highly disruptive member. It is best to do this during the group so the other members can share in the process and disposition. An abrupt departure of a disruptive member can be experienced as yet another traumatic separation. Even though final decisions are the facilitator's, group members are relieved that sensitive matters can be addressed in a caring way.

In our experience with this approach, it is exceedingly rare that members drop out. Over the years, we have treated many members who have challenged other groups and facilitators. We have been able to meet their needs when we maintain focus on the unnatural death and its effects.

While our program cannot promise coherence and autonomy, we can at least present a structured pathway through the morass of community scrutiny, the criminal judicial system process, and crime related bereavement distress as the family member finds and reestablishes his/her own footing on his or her own path.

RR Facilitator Characteristics

The facilitator will have had enough group support experience to demonstrate competence in initiating, reinforcing, and restoring group cohesion. Also, the facilitator will have a solid knowledge base and experience in support with participants with traumatic distress and separation distress. Facilitators will also require enough diagnostic insight to carry out an accurate pre-support assessment including the recognition of co-morbid disorders. The facilitator will have competence in managing the format and goals of short-term support, which dictates a high level of organizational skills. They will also have familiarity and skill with techniques of stress management and graduated exposure.

This combination of clinical capacities can be found in any level of clinician (psychiatrist, psychologist, social worker or counselor). Clinicians with extensive experience with participants unable to accommodate to unnatural death will presumably be more comfortable with this target population.

Expertise in the following areas is requisite for a RR facilitator:

- A capacity for encouraging the communication of visual imagery
- An active, energetic style of engagement
- Knowing how to intervene in an altruistic way
- Ability to teach group members how to become effective listeners and supporters because of the facilitator's own respectful and sensitive communication style.

Facilitator Attitudes

- A tolerance for ambiguity (i.e., accommodation to unnatural dying cannot be "completed"). Since accommodation will never end, it seems wise to approach RR as a beginning or a piece of the healing journey rather than insisting on it being a definitive end and goal. Acceptance of ambiguity will allow members the freedom and flexibility to develop their own tolerance for ambiguity instead of maintaining the rigid and repetitive imagery and behaviors of separation/trauma distress.
- Self-maintenance of calmness, hopefulness, genuineness and humor. Facilitators see their role as collaborators in helping members retell their traumatic death narratives in a way that provides modification and change in meaning. A facilitator who insists on maintaining authority cannot "author" someone else's narrative.

Facilitator Supervision

It is important for facilitators to plan ahead for each session. Facilitators can share in leading different assigned topics each week. This allows them to be active throughout the group. Perhaps one week a facilitator will open with check-in and the other end with the relaxation exercise. Both can share in the topics addressed each week.

It is also important for facilitators to debrief with co-facilitators and/or the supervisor after each session.

Aspects of treatment considered important to monitor are group dynamics (particularly cohesion), and specific approaches to any complications such as members' missed sessions, late arrivals or other forms of acting out.

Facilitators need to be supported in learning to hold a helpful stance with regard to group members' pleas for facilitator's direct interpretation of members' death imagery drawings. Specifically, how does a facilitator reply to the question, "What does this mean?"

Commonly, facilitators need to address members' questions about why sessions occur in the RR sequence.

Finally, supervising clinicians need to believe and remind themselves and group facilitators that RR is only a part of each group member's healing journey.

VI. TROUBLESHOOTING

We have structured this section around Dr. Jerome Frank's four principles of group treatment from his book "Persuasion and Healing": (1) a confiding relationship, (2) a healing setting, (3) a rational scheme, and (4) an active procedure. Of course, these are closely related and are not exclusive categories.

1. The Confiding Relationship: Trust, Confidentiality and Informed Consent

Concerns about confidentiality are common in groups. There is the issue of suicidality, for example: You will follow your state's laws, but you should also inform the group that if anyone is feeling suicidal you will want to talk with that person individually and you will do everything you can to see that they are kept safe. In this event you will have to breach confidentiality.

Before you start the group, make sure you are fully informed of your legal obligations if something is disclosed during group sessions which could jeopardize a case or which a group member wants to discuss but asks you and the group to "keep secret". Know exactly where you stand, now.

Reinforce at the outset of the group that while members may want to talk with their friends or family members about what goes on in the group or who or which cases are in the group, it is very important that they keep this information to themselves and within the group. Reiterate what a privilege it is to come together and how group support is built on trust and the commitment each has to the group as a whole. This is a place where group members can come with their private stories sometimes, different from the stories the media creates or the criminal-judicial system requires. With that said, ask again that group members keep confidential what happens during the group sessions.

Sometimes individuals are concerned about the screening assessments. Keep in mind that your purpose is clinical, that you want to be sure that the group is appropriate and a source of support for the individual at this time. You want to make this recommendation and decision with the individual, not for the individual. The "forms" they fill out help you learn from them, and you would like to have them come in again after they've been through the group to look at how things have changed compared to when they started the group. This will also be a good opportunity to talk about what they may want to do next. It is a focused way of "taking a look" with them.

Many times, put this way, people are grateful that you are helping them organize what they're feeling and put words to it.

Find out what your agency's policies are regarding informed consent and the use and storage of screening battery information and forms. The screening battery is a collection of clinical instruments upon which you will base your clinical decisions.

In the presence of traumatized family members and friends of crime- related victims, it is easy for facilitators and advocates to feel they are not doing enough. This is especially true because facilitators want to help; that's what we're supposed to do. So it is easy to over-extend, to let sessions run longer, to spend significant amounts of time on the phone with group members between sessions, to attend social events with group members, to lose the focus of the group. As this is time-limited, so is your involvement.

Members may choose to repeat the group, and they often do, but we want to caution facilitators to be sensitive to and aware of their own feelings of exhaustion, disorganization, frenzy and the boundless need to help. You are helping by offering the group. That is your role.

Be alert to members' needs for referral, for your needs for support from your professional network for group members who need more extensive support. You can't do it all.

2. The Healing Setting: Safety

Late Arrivals: Lateness is disruptive to group cohesion and coherence. While these interruptions cannot be avoided, we emphasize the importance of members' making every effort to contact the facilitator so that absences can be explained. Consider "bringing it to the group". Ask them how they feel when these things happen. Have them state this during the group session. Have them convey this directly to the group member the next time the member attends. Hold your boundaries; start and end the group on time.

No Shows: Will you call a member who doesn't attend and doesn't call? Yes. A brief call the following day is important. Check in briefly, let them know the group missed them and ask if they'll be there next time. Reiterate the importance of their calling you if they're not coming. Continue to give members your phone number and encourage them to call if they're not coming. We also point out that there are no "make-up" sessions so absences are irrecoverable.

Missing more than two of the ten sessions (particularly if they are consecutive) will disqualify members from continuing group, as will repeated tardiness. With RR there is insufficient time and attention for understanding the dynamics of tardiness or absence. If members dread attendance because of heightened trauma and separation distress, then acts of avoidance may be reduced with additional support and reinforcement of resilience. Members at the outset accept these limitations so that enforcement will be anticipated.

Intoxicated Group Member: What will you do if a member comes to a session while intoxicated? Would you ignore the obvious? No, and neither will the group. Kindly, ask the member if this is what is going on, acknowledge it in the group's presence and let the individual know you appreciate how important the group must be to him/her. However, you need to also let the member know that it is not appropriate for anyone who is intoxicated to come to the group.

Dropouts: What about a group member who drops out before the end of the ten sessions? Of course you want to talk with that person individually. Find out what makes it necessary for them to stop attending. Invite them to call you in the future if they are interested in being in the group. Let your group know you'll call that member, then inform the group of the individual's decision. You might want to invite the group to sign a card to send to that individual. This is an opportunity for your group to say "good-bye" in a "safe way" for them.

A Member Becomes Overwhelmed: What if a group member begins to dissociate or get caught up in trauma and lose track of relating to the group? We suggest that it is your role as facilitator to interrupt in an empathic way, acknowledging your feeling that something is going on with that member, that you want to hear what he/she is saying, but it feels like that person is becoming isolated from the group. Ask the group if anyone else is having the same feeling.

Let the group member know you're going to begin interrupting when the dissociating occurs. Reiterate that you want to hear, and the group wants to hear, about what is going on but when you feel that group member is getting isolated, you'll let the member know you recognize it and will try to help him/her stay in touch with the group.

You may find you are met initially with an angry response from that member, but if you remember what your role is, this will resolve within the group. That person knows on some level that he "loses it" when he talks about certain things, and the group feels anxiety escalate when this occurs. You as facilitator are not alone in feeling a loss of contact with the individual. Have the group work with this. Ultimately, this will be a group-building experience, something you do together.

3. The Rational Scheme: Coherence

Schedule of Group Sessions: This gives coherence to the group. There is a beginning, a middle and an end to the series of sessions. Content is specified. People can predict what will happen. They can count on it.

Information: Members learn in the group. They may not have known what traumatic grief is, what clinical depression is, how these and other problems they're experiencing may be associated with violent loss. They may learn others suffer acutely, that they are not alone.

Important Dates: It is very important for you to develop a system to keep track of the birthdays, anniversaries, holidays, and dates of death of the loved ones of the group members. During the check-ins ask whether there are any special dates coming up and what the group member's plans or thoughts might be with regard to that date. Ask other group members what they've done or what they're thinking about doing.

Added Sessions: If you feel the need to add sessions, be sure you have worked this through with your consultant. Is this your own anxiety about the group ending? Your own feelings about not "doing enough"? Remember that group members may repeat the group. Also, there is a great deal of value for your group members as well as yourselves in setting out the schedule from the beginning, working toward the "ending", experiencing the ending, and taking a planned break.

4. Active Procedure: Control and Hope for Change

Ritual: This word is used in the sense of beginning each session the same way, with refreshments available, with the room arranged the same, with nametags out, etc. Then there is the check-in. And the group always ends at a certain time in a certain way. Group members are active in getting to the sessions, in arriving on time, in choosing a seat in the circle, among other things they do to be "in group".

Participation: Listening is active. Talking together is active. Expressing emotion is active. Narrating and naming are active.

Ambivalence: If there is a member(s) who begins the group and is highly ambivalent about being there, you might want to acknowledge that this is difficult for that person to come in. Encourage that person to talk a bit about how they're feeling, to be "active" with that feeling. Actively engage the group. Ask if anyone else in the group has felt/feels this same way. Further, consider stating that out of respect for other members of the group, it is important that that person makes a decision by the next session and lets you know so you can communicate that to the group.

Appropriateness of Group: You can't always anticipate it, but it may become obvious to you after two or three sessions that you have an individual in your group for whom group is not helpful or appropriate at this time. What will you do?

Bring it to the group. If an individual's feelings are spilling into the group and the individual can't control this, encourage him to take a break, to get individual supportive counseling, to come back to another group in the future. Phrase this in terms of your concern for the group and for the individual. Encourage continued contact. Make a follow-up call. Let the group know what the individual's plans are for support.

Try to remember that facilitating a support group of any kind is an art AND a science. Things will come up unexpectedly. This, in fact, makes facilitating groups exciting and challenging.

You may find you have a "very difficult" group member. You may worry about some group member's or your own expression of emotion. Bring it to your co-facilitator, your consultant, and most of all, to the group. With only ten sessions, it is important to identify these difficult and complicating issues before the group begins.

Clinical Care Standards

Restorative Retelling facilitators will monitor each member's trauma and separation distress level during each session, since we specifically address these distress responses. If distress becomes too intense, the facilitator and group members will provide support for the reinforcement of resilience.

Progress assessment is an essential process maintained by each group member at the beginning and end of each group as they their progress in their ability to control their distress. The facilitator will be targeting diminished frequency and intensity of death imagery and avoidance with each session. However, this is not formally measured until the end of treatment.

Lack of progress is readily apparent, suggesting the need for strengthening and counterbalancing resilience. If distress worsens despite the support of the group, such an individual will require additional psychological support and/or medication for an emerging co-morbid disorder. This additional intervention will be accomplished during the group so the other members witness the facilitator's explanation and join in supporting this external intervention while committing themselves and the distressed member to ongoing Restorative Retelling.

VII. APPENDICES

Appendix A: Restorative Retelling Group Forms

Appendix A1 – Restorative Retelling Group Announcement

Virginia Mason
Separation and Loss Services

ANNOUNCEMENT

RESTORATIVE RETELLING GROUP

We are happy to announce the upcoming Restorative Retelling Group for

adult family members and friends suffering from traumatic grief as a result of a loved

one's sudden death due to homicide, vehicular homicide or suicide.

Group Format: **10-week closed therapy group**

Location:

Date/Time:

If you are interested in attending this group or would like additional information, you may call (206) 223-6398.

Thank you.

Laura Takacs, M.S.W., M.P.H.
Clinical Director
Separation and Loss Services

Appendix A2 – **Restorative Retelling Group Agenda**
Facilitators:

Session	**Date**	**Topic**
1		**Introduction of Members** **Focus**: Introductions and sharing stories
2		**Report on last week** **Focus**: Resources of support: family, friends, work, spiritual. Who or what was supportive in the past? What is your concept of death?
3		**Report on last week.** **Focus**: Model of prevailing and resilience. How have I changed?
4		**Report on last week.** **Focus**: Obstacles to prevailing, co morbidity, self-blame and revenge. Self-care.
5		**Report on last week.** **Focus**: Reunion session. Using journal, pictures, poetry, music, food or other special things, tell us about your loved one.
6		**Report on last week** **Focus:** Reunion Session continued
7		**Report on last week** **Focus**: Death imagery
8		**Report on last week** **Focus**: Death Imagery continued*
9		**Report on last week.** **Focus**: Family and Friends
10		**Report on last week.** Focus: Closing and going on
11		**One-Month Reunion** Focus: Review Pre and Post Measures

Appendix A3 – Restorative Retelling Group Progress Notes

Restorative Retelling Group Note

Patient Name:

Date of Service:

Length of Group Session: minutes Session Number:

Number of Group Members Present:

Topic:

Reported significant events and/or changes since last group:

Response to homework (if any):

Interventions and/or skills taught:

- **Psycho-education**
- **Identifying supports and skills for engaging support**
- **Identifying and increasing self care**
- **Emotion regulation**
- **Correcting maladaptive cognitions (including re-self-blame, revenge, injustice, power and control, intimacy, etc.)**
- **Creating trauma narrative/exposure/commemoration**
- **Creating trauma narrative/exposure/death imagery**
- **Skills training**
- **Other:**

Brief description of interventions in session:

Patient participation: *(Can include affect, level of engagement, progress, etc.)*

Additional notes (optional):

Homework (if any):

Provider Name and Credential: **Date Signed:**

Appendix A4 – Restorative Retelling Group Evaluation *(Sample)*

It has been a privilege to have you in the group. We hope that you have benefited from participating. Would you please make suggestions and give us your ideas and comments so we might improve this experience for others?

Please feel free to write your comments on the other side.

The topics we covered were among the following:

- **Introductions and sharing stories**
- **Feelings check-in prior to each session**
- **Relaxation practice**
- **Handouts**
- **Discussed sources of support**
- **Prevailing and resilience: how the death of your loved one has changed you**
- **Obstacles to prevailing: co-morbidity, self-blame and revenge**
- **Self-care**
- **Reunion session**
- **Death imagery**
- **Family and friends**
- **Resilience drawing, Closing and going on**

1. Which session, topic or speaker did you find to be the most helpful? What made this positive for you?

2. Which session, topic or speaker did you find to be the least helpful? Please tell us why.

3. Have you changed as a result of being in the group? How?
   See Changes Form to be completed by group members in Appendix.)

4. How could we improve the group to better meet your needs?

Thank you for your participation in this group. It has been a privilege to come together with you these past weeks.

Appendix A5 – Changes Form

SEPARATION & LOSS SERVICES

Please let us know . . .

Have you experienced any changes in your life since you started your sessions with us?

Name: _____ Date: _____

Signature: _____

Attended: Individual Group

Can we share this with others if we omit your name? Yes No

Appendix A6 – Feelings Repertoire

FEELINGS

Abandoned	Faithful	Lazy	Talkative
Accomplished	Fearful	Light	Tempted
Adequate	Foolish	Lonely	Tense
Aggressive	Frustrated	Lost	Thoughtful
Anxious	Free	Loved	Threatened
Arrogant	Furious	Low	Trustful
Bashful	Good	Mad	Unconcerned
Bitter	Generous	Meditative	Unconditional
Bold	Gloomy	Mean	Undecided
Bored	Goofy	Melancholic	Uneasy
Brave	Graceful	Moody	Unkind
Burdened	Grieving	Numb	Unruly
Calm	Happy	Pained	Violent
Capable	Honored	Panicked	Vital
Cheated	Hopeful	Paranoid	Vulnerable
Concerned	Horrible	Peaceful	Vivacious
Confident	Helpless	Pleased	
Curious	Hurt	Proud	
Determined	Indifferent	Regretful	Warm
Disappointed	Idiotic	Relaxed	Weepy
Distracted	Ignored	Relieved	Wicked
Disturbed	Infuriated	Remorseful	Withdrawn
Divided	Interested	Restless	Wonderful
Doubtful	Isolated	Righteous	
Eager	Jealous	Sad	
Ecstatic	Jerky	Satisfied	
Energetic	Jinxed	Scared	
Envious	Joyous	Shocked	
Exasperated	Judgmental	Suspicious	
Exhausted	Just	Sympathetic	

Appendix A7 – Styles of Grieving

Styles of Grieving
Intuitive/Instrumental Grievers

Instrumental Grievers

- Are private – they have less access to tears and minimal display of emotion but they are indeed grieving.
- Release of emotion is often through cognitive and behavioral pathways.
- They want manage their grief and so their preference is to talk about issues rather than feel the feelings.
- They describe their grief in cognitive or physical terms –"It is as if I have been punched in the stomach", "It's gut wrenching", It's like a cold chill", "I'm wound like a top".
- They are practical, pragmatic, sequential problem solvers and they look for ways to fix their grief.
- Are action-oriented – there is a need to be doing. Creative activities such as poetry, art, and music may provide an outlet for emotions, as well as volunteering or promoting a cause.
- Are future-focused – their goal is to move efficiently through the grieving process to the other side.

Intuitive Grievers

- Grief is experienced as intense feelings
- Feelings are expressed easily, comfortably and emotionally through tears.
- The outward expression of their grief mirrors their inner experience.
- They process their grief by telling and retelling the story/the narrative of the death/loss.
- They are natural meaning makers and so as they seek new identity after the loss they question its impact on the narrative of their story.
- They seek to understand the "why" in the loss.
- They often describe grief in emotional terms "I feel so sad", "I feel lost and afraid", "I feel vulnerable".

From "Grieving Beyond Gender" by Terry Martin and Kenneth Doka

Appendix A8 – Common Responses to Trauma

Common Responses in Traumatic Loss

Trauma Responses

Physical

- Recurring feelings as if the just happened
- Exaggerated startle response
- Anxiety, panic attacks
- Extreme and/or enduring changes in appetite
- Oversensitivity to noise

Emotional

- Intense and contradictory emotions
- (e.g. rage/sorrow, sadness/relief)
- Feelings of revenge
- Feeling "frozen", overwhelmed
- Dissociation (feeling out-of-the-body)
- Hypervigilance, always on guard

Cognitive

- Scattered thoughts
- Ruminating or obsessive thinking
- Recurring imagery of the death
- Nightmares
- Fear for own safety or the safety of other loved ones
- Avoidance of thinking or talking about what has happened, and/or of places and people associated with the event

Spiritual

- Shattered worldview – no longer a supposition of safety in the world
- Change in spiritual beliefs
- Search for meaning, purpose

Grief Responses

Physical

- Change in sleep patterns
- Significant weight gain or loss
- Digestive problems
- Restlessness
- Headache, muscle ache
- Fatigue
- Frequent sighing

Emotional

- Feelings of anger, guilt regret
- Feeling irritable
- Crying at unanticipated times
- Overwhelming sense of sadness
- Intense loneliness and sense of isolation
- Need to repeatedly retell details of the loss

Cognitive

- Forgetfulness
- Poor concentration and ability to focus
- Loss of time perception
- Sense of unreality about the death
- Imagining hearing, seeing or smelling the deceased loved one, especially in familiar places

Spiritual

- Anger at God/Universe
- Loss of hope
- Faith is often either shaken or strengthened

Adapted from Randie Clark, MA, CCC, and Avril Nagel, "When Your Child Dies"; Jack Jordan, PhD, "Traumatic Loss: New Understanding, New Directions".

Appendix A9

How Have You Changed? Handout

As you look through the following list, consider how you've changed since the person you loved died. Are there others you might add?

1. **Physical**
   - Significant weight gain/loss
   - Headaches
   - Frequent illness
   - Stomach problems
   - Heart problems
   - Not enough sleep
   - No exercise
   - Eat irregularly
   - Ache all the time
   - Decreased/no energy
   - Frequent accidents
   - Cancer
   - Digestive problems
   - High blood pressure
   - Sleep a lot
   - Poor nutrition
   - Abusing substance(s)

2. **Spiritual**
   - No sense of direction
   - No joy or pleasure
   - Sense that nothing matters
   - Feel alone
   - Meaningless
   - No connection
   - No ritual

3. **Emotional**
   - Depressed mood
   - Despondent
   - No interest in friends
   - No routines
   - No dreams
   - Not interested in family
   - Can't concentrate
   - Rages/increased anger
   - Irritable
   - Just drag through the days
   - No interests
   - Hopeless
   - No interest in activities
   - No future
   - Not creative
   - Easily frustrated
   - Forgetful
   - Mood swings
   - No tolerance

4. **Productivity/Work**
   - Became unemployed since the loss
   - No ideas
   - No interest in work
   - Co-workers of no interest
   - Just hanging in there
   - Feel trapped

Financial
- Don't spend any money
- Behind in paying bills
- Things are out of control
- Have spent way too much
- Have incurred late payment charges
- Don't care

Are there any other things you would add? How have you been dealing with these changes?

Appendix A10 – The Lock Box Exercise

The Lock Box

Sit back and take a few diaphragmatic breaths to be comfortable. You may wish to close your eyes as we go on this brief journey together.

Imagine if you can, a box. It is completely of your own design. It could be an exotic carved wooden box from another culture; or it might be something quite simple, like a small metal box for filing…it's your choice, it's your design. It belongs only to you. [pause]

Now, notice that there's a key in the lock on the box, as you approach it slowly. When you're ready, you can turn the key and open your box. Notice that it is quite empty, with plenty of room for storage and organizing things.

And when you are ready, imagine if you can, yourself placing all that you may wish to store there: painful memories; perhaps disturbing images; maybe tears and overwhelming emotions about your own loss.

Can you try to park them there for safekeeping…for now?
[pause]

And now, after you've been able to place at least some of these things there, can you see yourself step back from your box…key in hand. Take a good look at your key.

And only when you are ready, imagine yourself closing the lid on your box and slowly re-locking it for future visits. You can know that you are in charge of when you return to it; the privacy you have with re-visiting it; and with whom you can share the important contents.

And now, if you can, take one more look at your box, and feel the key in your hand. And decide where you will store the key, knowing you can make the choices about when and where you'll return to your box, to unpack and explore what you've decided to place there.
[pause]

And now, when you're ready take three slow and easy deep breaths, and when you're ready, open your eyes and return to our group.

"The Lock Box" by John Powers, LICSW

VIII. RECENT LITERATURE ON COMPLICATED GRIEF & VIOLENT DEATH

Complicated Grief References - 2011-2013 - Adults - compiled by Dr. Kathleen Nader

Treatment Manuals: Violent Death Bereavement

Trauma/Grief-Focused Group Psychotherapy Program (children and adolescents)
UCLA Trauma Psychiatry Program, 2001
Layne, M.L., Saltzman, W. R., Pynoos, R.S.

Salloum, A., (2015). Grief and Trauma in Children: An Evidence-Based Treatment Manual. Routledge, New York. http://www.amazon.com/Grief-Trauma-Children-Evidence-Based-Treatment/dp/041570829X

Salloum, A. (2004). Group work with adolescents after violent death: A manual for practitioners. Philadelphia, PA: Brunner-Routledge.

NATIONAL CHILD TRAUMATIC STRESS NETWORK

CHILDHOOD TRAUMATIC GRIEF Reference and Resource List

Mental health professionals are encouraged to consult the following professional articles and resources to gain an understanding of *childhood traumatic grief*. Background information sheets about the condition, based on these materials, as well as assistance locating an appropriate mental health professional with expertise in *childhood traumatic grief* is available from the National Child Traumatic Stress Network (NCTSN) at (310) 235-2633 or (919) 687-4686 x302 or at their web site **www.NCTSNet.org**.