

# **MANUAL FOR RESTORATIVE RETELLING IN A CORRECTIONAL SETTING**

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## FOREWARD

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The Washington State Department of Corrections allowed us to work in facilities for youth (King County Juvenile Detention and Echo Glen Children's Center) and adults (Purdy Correctional Facility for women and McNeil Island Correctional Facility for men). Without the cooperation of the administrative and clinical staffs of these institutions, this work could never have begun.

Richard Gold, a poet, has worked with the groups at the King County Juvenile Detention Center, Echo Glen Children's Center and McNeil Island. He is a highly creative and innovative catalyst for "putting words to the unspeakable" and his writing exercises are also included in the appendix.

Although a number of people reviewed the text of this manual, I am primarily responsible for what is written. Omissions or oversights in this sort of preliminary manual are inevitable, but unintentional. I apologize in advance.

Finally, I want to thank those who participated in the groups for allowing me to join them in their attempt to restore themselves. These are always very powerful and evocative groups and it is a privilege to share in the retelling.

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### **Background:**

Community studies of adults and children have documented the psychological effects of the violent death of a close friend or family member (from homicide, suicide or an accident). For a time, anyone who was emotionally attached to the deceased experiences a mixture of trauma and separation distress (Rynearson – 1999). In addition to pining and searching for their presence (separation distress), they also identify with their terror and helplessness as they were dying – through vivid flashbacks and dreams of the dying (trauma distress) though they rarely witnessed it. These intense responses of separation and trauma distress may persist for several months, and recur with reminders of the dying, but the vast majority of adults and children are able to adjust to that singular event.

It appears that kinship is a risk factor for non-accommodation – 30% of mothers and children may remain traumatized to the dying for many years (Murphy – 1999). Not surprisingly, a childhood history of abuse and/or neglect and a previous history of psychological dysfunction and treatment comprise additional risk.

Juvenile and adult prisoners have an alarmingly high exposure to violent dying before their incarceration. Epidemiological surveys reveal that at least 50% have experienced the death of a family member or close friend from homicidal, suicidal or accidental dying and many have experienced not just one, but multiple violent deaths (Steiner – 1997). Despite the commonality of violent dying experience for prisoners, there has been little study of its effects or treatment.

High rates of violent dying are associated with economic poverty, developmental history of emotional neglect, physical and sexual abuse, polysubstance abuse and deviant social behaviors – and many inmates have experienced this combination of psychosocial factors long before their own deviancy and incarceration (Berman – 1996, Warner – 1996). Surveys have also documented the high frequency (40-60%) of psychiatric disorders in juvenile and adult prisoners.

Violent dying in someone with this bio-psycho-social background, while painful and traumatic may be just one event in a procession of tragedies that is numbly avoided instead of articulated. It is unusual for an inmate to have talked about their private response to the violent death of a close friend or family member. More commonly they accommodate by repressing their intrusive thoughts or feelings of the dying with drugs and alcohol, or engage in some compensatory act of retaliation or risk taking behavior. These compensatory and dysfunctional behaviors of substance abuse and retaliation after violent dying have undoubtedly contributed to a number of the criminal activities resulting in the incarceration of some prisoners.

Since incarcerated youth and adults present with psycho-social factors that compound the risk of non accommodation through (1) high exposure to violent dying, with (2) highly dysfunctional responses to its emotional effects, it is challenging to design an intervention that will help them. They are far from “ideal” as potential treatment responders. Violent dying is only one in a long line of traumas. However, incarceration enforces a hiatus in their dysfunctional behaviors and substance abuse, and this carries a therapeutic opportunity. For the first time in many months or years, enforced sobriety and containment allows them to openly experience and deal with the repressed thoughts and feelings associated with the event of violent dying.

#### **Available Interventions:**

There has been no report of an intervention specific for incarcerated youth or adults for dysfunctional distress related to violent death.

In recent years, there has been one report of a time-limited group intervention designed for inner-city youth (Salloum, 2001) and published reports describing a community-based intervention for adult family member and friends after a violent death (Rynearson, 1999; Rynearson 2001).

This later intervention has been named ***Restorative Retelling (RR)***. After systematically screening to ensure their suitability for a short-term intervention, subjects attend group sessions for 10 consecutive weeks. The groups are closed and follow a written agenda that encourages specific accommodation to trauma and separation distress through clarification and group discussion, exercises for skill enhancement, restorative retelling of the dying through drawing and poetry and

a reinforcement of resilience that can be continued after group termination. A separate manual has been published and is available upon request. **RR** has a low drop out rate (less than 20 %), is free of risk (there have been no casualties) and is associated with a significant lowering of standardized and reliable measures of distress (Rynearson – to be published).

For the past two years the authors have applied a modification of this intervention with incarcerated youth and adults. These preliminary clinical trials have been encouraging -- inmates' attendance is active and consistent (a drop out rate of only 10%), there have been no casualties from the intervention, and measures of distress show a significant decrease at the completion of the intervention (Rynearson et al – to be published).

This manual presents a theory and rationale for an intervention specific to the correctional setting, a specification of its active ingredients and a recommended format and content of sessions to serve as guide.

Before presenting those details, we need to emphasize several essential pre-conditions for the intervention:

*(1) A mechanism for screening the facility's population for the prevalence of violent dying and identification of inmates for intervention is foundational. When administrative and clinical directors recognize that a majority of their population has suffered the violent death of a friend or family member, a short-term intervention for those who continue to suffer becomes an obvious need.*

*(2) The culture of a correctional facility is so highly regulated and hierarchical that any proposal for a novel mental health intervention must come from within the institution. While the support of the clinical director and manager of the mental health services within the institution are mandatory, so is the approval of the superintendent and chief administrator.*

*(3) Once approved, the intervention needs a wide spread announcement and assurance of its relevance and practical goals for all levels of correctional staff -- to support inmate attendance.*

*(4) The intervention should be carried out within the mental health service where confidentiality and safety for the inmates can be ensured. Selected members of the mental health staff attend the intervention as training-participants and coordinators of support for inmates between sessions.*

*(5) The intervention is voluntary and subjects may elect to drop out at any time. Their sentence or probation will not be influenced by the intervention - either by successful completion or refusal to attend.*

**Limitations:**

Offering intervention to prisoners should include clear rehabilitative goals; to not only diminish distress, but to decrease risk of further criminality and recidivism. While we have strong anecdotal evidence that dysfunctional responses to the violent death of a close friend or family member have been directly linked to criminal acts and imprisonment (and therefore deserve rehabilitative intervention), we do not yet have outcome data demonstrating diminished criminality and/or recidivism following **RR** for dysfunctional traumatic grief. An outcome study of that sort demands a rigorous follow up and monitoring – well beyond our recent preliminary institutional trials.

Rehabilitation is a multi-faceted operation involving multiple levels of support, training, education and clinical treatment. While **RR** may be a valuable addition to the list of rehabilitative services, it has no proven long-term consequences for criminality or recidivism.

Another limitation of **RR** has been purposeful and designed. The clinical focus with this short-term program deals directly with the separation and trauma distress of the violent dying. Many inmates present with multiple experiences of separation and trauma beginning in their early childhood, that continue into adolescence and adulthood (and continue in prison as well), but those experiences cannot be explored and resolved with **RR**. While an awareness of resources of resilience from life before imprisonment is important, **RR** actively discourages uncovering of distress that is unrelated to the relationship with the deceased and the details of their dying. To encourage an unlimited exploration of traumatic experiences outside of the dying would be

overwhelming for these participants (many of whom are severely traumatized) and would overwhelm the limitations of **RR** as well. The primary purposes of **RR** are restorative and constructive – to restore resilience and construct new skills and strategies to gain a new accommodation to the experience of violent death.

## **Theory and Rationale for Restorative Retelling:**

### **The Story**

After the violent death of a close friend or family member it is natural to feel stunned and unable to believe that this dying has happened. It is too horrible and terrifying to accept.

A fundamental way that the mind first tries to accommodate to this overwhelming event is to imagine and then retell it as a story. One of the fundamental mental paradigms of the human mind is the “story form”. Constructing a story around an experience of any kind brings order and meaning. A story has a beginning, middle and an end -- 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.

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

There are also compensatory or secondary stories whose purpose is to make the dying “unhappen”. They often occur in combination rather than alone:

- 1) 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.”*
- 2) Story of **retaliation** – *“Someone else is responsible for the dying. I am going to find that person and get even.”*
- 3) Story of **rescue** – *“I imagine how I could have stopped the dying and saved my loved one.”*

- 4) Story of **reunion** – *“I need my loved here with me so I can be safe from what’s happened.”*
- 5) 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 during the first days and weeks of traumatic grief, but with the support of family and friends and the finality of the funeral and memorial service, the memory of the violent dying and its stories fade. Most people are able to accommodate by engaging in a spontaneous restorative retelling through meaningful rituals and commemoration of the deceased with friends and family. The living memory of the person gains ascendancy and becomes stronger than the memory of their dying.

If the violent dying was a homicide or accident, the media, police and the court are also involved in retelling the dying – they promise that they can solve it, and carry out a process of retribution for the deceased and punishment for the perpetrator. Sometimes the public retelling of the dying by the media, police and courts is inaccurate, insensitive and misleading and complicates the private retelling. It is difficult for the friend or family member to finally accommodate to the dying until this public processing of the dying story has been completed.

### **Separation and Trauma Distress**

Our model proposes that trauma distress and separation distress are concurrent responses to violent dying. While the thoughts, feelings and behaviors of trauma and separation distress are not specific, they are roughly separable into two syndromes:

**Table 1**

	<b>Trauma Distress</b>	<b>Separation Distress</b>
<b>Thoughts</b>	Reenactment	Reunion
<b>Feelings</b>	Fear	Longing
<b>Behavior</b>	Avoidance	Searching



Our theory suggests that dysfunction is associated with repetitive, intrusive, and enervating thoughts, images and stories of the intersecting memories of the deceased, the dying and the self:

*(1) Dysfunctional images of the deceased contain their terror and helplessness as they were dying.*

*(2) Dysfunctional images of the dying recur as an involuntary witnessing of a disintegratory drama that cannot be controlled.*

*(3) Dysfunctional images of the self persist as being remorseful, retaliatory, rescuer, helpless without the deceased, or ultimate protector for remaining friends and family members.*

Further, our theory proposes that 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 **RR**.

Before dealing with separation distress, someone who is highly traumatized by a violent dying needs to be stabilized, and RR 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 they will disappear in the nameless swirl of terror and helplessness -- as did the deceased.

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

**RR** first focuses on strategies to restore resilience, then exercises to retell and commemorate the living memory of the deceased and self, then exercises to retell and survive the memory of the violent dying and finally exercises to memorialize the memory of the deceased so the member can reengage with their own living.

## Clinical Uniqueness of the Prisoner

Youth and adult prisoners present vulnerabilities and resistances that require modification of the **RR** agenda and clinical focus:

*(1) The vast majority of prisoners are substance abusers. The persistent use of narcotics, psychedelics, tranquilizers or alcohol interferes with the normal registration and recall of experience, and particularly traumatic experience that is processed in a fragmentary way by the soberest of subjects. Some prisoners may be overwhelmed by past experiences of violent dying that begin to register and recall with enforced sobriety, and there is some evidence that these individuals may have been more vulnerable to trauma distress, and were self-medicating with illegal substances. Other prisoners who have experienced violent deaths while intoxicated notice little trauma distress when withdrawn from substances – suggesting that they were not vulnerable to trauma distress at the time of the dying.*

In any case, vulnerable to trauma or not, someone with a long history of substance abuse may have a chronic impairment in resilience. Their chronic intoxication may have provided an artificial sense of safety, separateness and autonomy, (“If I’m high, nothing can bother or touch me.”) and they are unpracticed in retelling their own painful experiences in a reflective or insightful manner. They are often expert in “making small talk”, but cannot begin to spontaneously reveal themselves before others.

*(2) The majority of prisoners have co-morbid psychiatric disorders. It is crucial to screen for these disorders, because some are responsive to specific medication, and some (mental retardation or active psychosis) are contraindicated for **RR**. Character disorders are also frequent among prisoners (though untreated substance abuse and depression may mimic character syndromes). Prisoners with sociopathic, borderline or narcissistic disorders are so manipulative and egocentric that they should be excluded from **RR**. They can be enormously disruptive to the cohesion and trust that needs to be fostered in a short-term group. It is not unusual for the group leaders to discover an undiagnosed character disorder in a group member that declares itself after the group has had several meetings – and we will talk about managing that clinical dilemma in a later section of the manual.*

*(3) Most prisoners are distrustful of themselves and others. Often their life circumstances were such, that distrust and deceit were the most readily available options for survival. Prison may be safer and more consistent than their “outside” life, but it is still a highly dangerous and threatening place. Saying the wrong thing to the wrong person can have frightening consequences. It is crucial that the group and co-leaders actively develop norms to ensure safety and confidentiality from the moment that the group first convenes. These norms often need to be reinforced and re-endorsed at the beginning of each session.*

*(4) A minority of prisoners are perpetrators of violent death. Some perpetrators who are serving long sentences recognize their own shame and remorse and ask for intervention. More often than not, they were intoxicated and the homicidal act was impulsive or negligent (drunk driving) rather than coldly reasoned and planned. They ask for an opportunity to retell a violent dying story – to restore their own identity from the corrosive label of murderer. However, that story is categorically distinct -- identified with the killer rather than the more common identification with the victim. **RR** cannot contain such divergent stories at the same time. Perpetrators need their own group and should not be included with those who are grieved over the traumatic death of the victim, unless they are there to work on the violent death of someone they loved.*

### **Goals and Goal Setting:**

Potential group members are self referred, or referred by the mental health clinicians and other providers of the institution, for pre-screening (to be described). From the moment that the interview begins, the goals of **RR** are clearly and concisely described and repeated as the evaluation progresses. The potential group member readily recognizes the centrality of the dying story and its association with trauma distress because that is so fundamental after a violent death. Often they consider the intervention because they cannot stop themselves from retelling the violent dying story so they appreciate the relevance of reprocessing that traumatic narrative so the living memory can be remembered more than their dying.

After agreeing to attend 10 consecutive weekly group sessions, we review a handout of the week-to-week agenda so each member has a clear expectation of the format.

The goal of **RR**-- to moderate trauma and separation distress through a restorative retelling of commemoration and then the reenactment story and secondary stories of remorse, rescue, retaliation, reunion and protection -- is repeated at the beginning of each session and each member reports their progress from the week before. This allows a direct monitoring of the level of distress in each participant and adjustment of intervention from week to week.

At the time of screening, each member fills out standardized self-report measures of traumatic grief (to be described) that are repeated at the end of the intervention. A follow up group is scheduled to review the test results. At that time the group members can compare their own pre/post measures which serves as another tangible indicator of goal completion.

**Contrast with other Treatments for Unresolved Grief:**

(1) **RR** is time limited and intensive. Support group or individual counseling meet less frequently, for longer periods of time and are open-ended. Open-ended support groups are unable to screen or maintain selectivity so are vulnerable to long-term members with significant co-morbidity who need attention for their long-term conflicts. **RR** begins with the clear expectation of a termination date that is emphasized at the beginning of each subsequent session.

(2) **RR** is focused on the dysfunctional responses to the violent dying. Our time limitation and written agenda does not encourage consideration of personal or interpersonal dysfunction beyond the relationship with the deceased and the experience of the violent dying.

(3) **RR** contains a specific staging of techniques and exercises -- to modify trauma and separation distress through a restorative retelling of commemoration and then the primary and secondary stories of the dying. To our knowledge, the combination of stress management and structured imaginal exercises through poetry and drawing in a staged format (to be described) is unique to **RR**.

## **SPECIFICATION OF ACTIVE INGREDIENTS**

### **Specific, Unique and Essential Interventions:**

(1) **Resilience** (the capacity for feeling safe, separate and autonomous i.e., not merging with the dying imagery) is reinforced during the initial sessions. This reinforcement returns a requisite psychological stability upon which subsequent imaginal modification can occur. Without resilience, the approaching imaginal exposure provokes unbearable distress and compensatory avoidance.

(2) **Restoration** of positive, non-traumatic imagery of the deceased and self are actively initiated through “commemorative” sessions. This commemorative imagery of the self and the deceased as vital and meaningful serves as a positive counterbalance to the intrusive imagery of the self and deceased disintegrating with the dying. Re-establishment of antecedent imagery also fosters a firmer basis for establishing and maintaining detachment.

(3) **Reexposure** to the violent dying imagery through imaginal exercises of poetry and drawing is the final unique strategy of **RR**. However, it cannot begin until the group member can tolerate the accompanying terror and helplessness. With re-established resilience and a restoration of the living memory of the deceased and self, the violent dying story can be told with a change in perspective and mastery. Now the story “belongs” to the teller and can be retold at will rather than intruding.

### **Essential but not unique interventions:**

*(1) Clear, concise and repeated presentation of theory and goals.*

*(2) Constant attention to group dynamic with emphasis on maintenance of group cohesion. **RR** cannot begin or proceed unless the individual member trusts that other members are empathic listeners and helpers. Group trust is built upon the opportunity for mutual retelling and the reassuring support of other group members ensures that disclosure is safe and hope can be restored.*

*(3) Flexibility in co-leaders style of interaction. The group agenda is a structure that allows a reframing of the violent death experience. The agenda is a frame rather than a rigid formula. The*

*group members chart their own path toward a restorative retelling, and so long as they remain focused on that task and follow the agenda as a guide, the co-leaders do not insist upon a precise adherence to topics or exercises. Juveniles sometimes need more direction than adults, but the maintenance of group morale requires that the group members determine the fate of the group – and look to the co-leaders as involved members and teachers, rather than authoritarian taskmasters. The powerful effects of group retelling come from the group, not from the “power” of the co-leaders. The exercise of power is so pervasive in the prison culture that co-leaders are wise to avoid it.*

*(4) Respect for each of the group members and their memory of the violent dying is mirrored and emphasized. Juvenile and adult prisoners have gone through multiple life events that have eroded their own sense of self-respect and efficacy – including their identity as a prisoner. The co-leaders actively reinforce the efficacy of members by positive reinforcement and encouragement of their efforts to interact.*

#### **Prohibited Interventions:**

*(1) Premature reexposure to violent dying imagery will be met with avoidance and premature termination. Resistance and avoidance need to be respected. No one should be placed in a “hot seat” where they are forced to reveal themselves.*

*(2) Pressure to cry or express anger over the dying is disrespectful. Direct confrontation of that sort diminishes the sense of control, and that might trigger a strong response from a prisoner who is struggling to maintain what little personal and interpersonal resources of control that remains to them.*

*(3) Dogmatic interpretations that link dysfunctional responses from the violent dying with dysfunctional childhood experiences are counter-productive. A regressive technique of that sort risks making the inmate feel more helpless and disrespected than before. Interpretations should be restorative and supportive rather than revealing of deeper problems and conflicts.*

#### **Patient and Therapist Relationship:**

The co-leaders are actively involved in the group process – and particularly as the group is first forming. As members “test the waters” by first talking about personal experiences, the co-leaders actively praise and encourage their efforts, and supportively interrupt other group members if they

become too challenging or critical. These direct confrontations become increasingly rare for the co-leader to make. As other group members appreciate their protective purpose (to maintain the autonomy, sufficient time and respect for each member) they begin to model the co-leaders' behavior and become less confrontational.

The co-leaders actively clarify the elements and goals of restorative retelling. Each session contains a brief didactic session followed by group discussion. These clarifications are particularly important during the first three or four sessions when group members need more structured understanding of the purpose of RR. However, as group members focus on their commemorative and death imagery, the content and purpose of RR is enacted rather than taught.

Co-leaders questions and interpretations are open-ended and tentative so that an attitude of genuine curiosity and tolerance is conveyed. Each member finds their own pathway toward accommodation and the co-leaders reinforce a respectful confidence that the member can increasingly serve as their own guide.

Since **RR** is time limited, a strong reassurance comes from the co-leaders assumption that the group member can emerge from **RR** with newfound insights and skills that allow ongoing mastery of the dysfunctional response to violent dying. It is safer and more effective for them to reflect upon and retell future traumas, than to thoughtlessly respond through impulsive behavior or substance abuse. This establishes a movement and direction for **RR** beyond termination. Co-leaders communicate the strong message that the **RR** goals are limited to a beginning adjustment to the violent death experience and serve as a solid basis for future accommodation.

*Accommodation to violent death is a lifetime challenge instead of a short-term cure.*

## **SCREENING AND PREPARATION**

### **Indications:**

The individual is willing to consider **RR** after the violent death of a family member or close friend (from homicidal, suicidal or accidental dying) that has led to dysfunctional responses of trauma distress and separation distress (traumatic grief) for six months or longer after the death.

### **Structured interview:**

Each potential group member may be individually interviewed for 30 minutes or several group members may be interviewed in a small group setting (to observe their capacities for empathy and listening – and their capacity to tolerate the stories of other members) for an hour. In either context, the interviewer tries to establish the degree and sources of resilience available to the subject in the past and present. This is reflected by focused and purposeful questioning – to search for strength instead of weakness or psychological disorder:

Previous history of trauma: *What and who helped you cope?*

Previous history of death: *What and who helped you cope?*

Resources of support: *What or who can you count on for stability? Family, friends, work, church or spirituality?*

Concept of death: *We can't know what happens after death – but do you have some idea or belief that is comforting and reassuring for you and the person who died?*

Co-morbidity: *Have you needed help before (counseling, medication, hospitalization)?  
What or who helped?*

Narrative of violent dying: *Primary story of the dying (reenactment thoughts, flashbacks, dreams)?  
If yes, how often – monthly, weekly or every day?  
Secondary story of the self (remorse, rescue, reunion, retaliation or protector)?  
If yes, how often – monthly, weekly or every day?*

At the end of this inquiry, designed to highlight resilient capacities, belief systems and an inventory of external supports, the interviewer and group member discuss how **RR** might lead to a more restorative retelling of the violent dying and diminish trauma and separation distress.

### **Contraindications:**

- 1) active drug or alcohol abuse



- 2) active psychosis
- 3) intellectual handicap with diminished memory capacity and affective control
- 4) incapacity for trust, disclosure, safety, control or hope

The interviewer explains that because of the intensity and time limitation, these individuals might experience more, rather than less, distress with **RR**.

**Preparation:**

- 1) review agenda and schedule
- 2) sign informed consent
- 3) complete self-report measures

**COMPATABILITY WITH ADJUNCTIVE TREATMENTS**

**RR** is so focused and time limited that it rarely complicates or is complicated by other interventions. **RR** does not unduly influence the ongoing treatments of inmates who are commonly taking psychotropic medications and engaged in concurrent cognitive-behavioral therapies. Obviously, it is crucial to inform the other active treatment providers of the goals and limitations of the group to ensure their support and feedback.

**TROUBLESHOOTING**

**Strategies for Common Problems**

1) **Missed sessions** are disruptive to group cohesions and coherence. In a correctional institution, group members are often escorted or summoned to sessions so that tardiness is an unusual occurrence. However, when a member is purposefully late or refuses to attend without notifying the co-leaders, the entire group is left to wonder about the absence – and this can be diverting and time consuming. It is difficult for a participant to maintain an understanding of the other members' restoration or a supportive engagement with the group if more than two sessions are missed. Because of the time constraints, there is too little time to resolve the resistance underlying tardiness or absence. A limitation on missed sessions is emphasized before **RR** begins: *You cannot remain in the group if you miss more than two sessions.* Knowing this limitation is corrective.

An unavoidable interruption in attendance is sometimes dictated by the demands of

the institution for transfer of inmates to court or to another institution. That decision is impossible to predict or delay.

2) *Group members may become disrupted* by the interpersonal demand of disclosing to other inmates, or by the pressure to focus on commemoration and death imagery. Instead of recognizing their fear as a discomfort that can be shared and resolved, a member might withdraw or defensively criticize or distance themselves from the other members. Usually the co-leaders can directly address this passivity or irritability, and with the support of the other group members this fear can be normalized, openly expressed and mastered.

However, when a member's withdrawal or irritability increase, and now include demands for attention or bullying other group members, and persist or worsen despite the best efforts of the co-leaders and other group members, it is important to place limitations on those behaviors as well. It is so unusual for these disruptive behaviors to persist in the active **RR** format, that the co-leaders should consider that the member's disruption is most probably a reflection of a long-standing character disorder. If there is more than one disruptive group member, it is increasingly difficult for the group to work around the manipulation, distrust, demands for attention and bullying that they reinforce between them.

The co-leaders have ultimate control over the composition of the group – before it begins and as it proceeds – and if the productive work of the group and the **RR** format is being jeopardized by a highly disruptive member or members, then an alternative therapy should be arranged. It is important for that decision to be communicated at a meeting with the entire group in attendance, and for the co-leader to remain respectful of the intense needs of the disruptive member that are legitimate, but cannot be addressed in a time-limited group. By transferring the disruptive member to another resource of help (if they want to be helped) the group and co-leader try to avoid a message of humiliation or rejection. An abrupt departure of a disruptive member can be experienced as yet another traumatic separation. Even though the co-leaders make the final decision, group members are relieved that termination can be addressed in a caring way.

In our experience with **RR**, this sort of enforced transfer is exceedingly rare. We have treated many subjects who have challenged other groups and therapists, and by maintaining their focus and engaging them in retelling, they have responded.

3) **Clinical care standards** are exercised by the co-leaders throughout **RR** to prevent problems. Progress in mastering distress is self-reported by each member at the beginning and end of each session. The co-leaders monitor the signs and symptoms of trauma and separation distress during the session as each member contributes. If reported distress is too intense, the co-leaders and group members provide support and reinforcement of resilience. The co-leaders also focus on diminishing the frequency and intensity of primary and secondary stories of the violent dying.

Lack of progress is readily apparent suggesting the need for strengthening resilient capacities. If distress worsens despite the support of the group and the co-leaders, the highly distressed group member may require additional supportive psychotherapy and/or pharmacotherapy for an emerging co-morbid disorder.

Requests for additional support or consultation outside the RR format are made during the session so the other members witness the co-leader's explanation and join in supporting this external intervention while committing themselves and the distressed member to ongoing **RR**.

## **SESSION STRUCTURE AND FORMAT**

### **Session Structure:**

Sessions last 90 minutes and begin and end on time.

Co-leaders refer to the written agenda at the beginning of each session to announce the topic of the session and remind members how many sessions remain.

Each session begins with a brief "check in" for each member. It is important for the more avoidant or introverted member to report their status so they can be included in the interaction. The members are told to focus on how their experience of the violent death has changed since the last session because that is our primary concern and that is what we need to "check".

One of the co-leaders then presents a simple clarification of one or several of the principles of **RR**. During the first four sessions these brief “lessons” provide a more coherent framework for the member’s understanding of: (1) resilience, (2) restorative retelling, (3) restorative reconnection (4) a place for yourself in retelling. Each of these presentations lasts five or ten minutes with another 10 or 15 minutes of discussion and alternatives for skill enhancement and mastery of the principle.

Next, the group engages in exercises of poetry writing and drawing to more fully express and experience resources of resilience and to begin preparing material for their presentations of the commemorative and dying image of the deceased.

Finally, one of the co-leaders may lead the group in stress reduction and guided imagery exercises for 5 minutes to close the session.

The sessions follow a rough time schedule for each session and a predictable, succession:

Sessions 1-4

- 15 minutes “check in”
- 20 minutes lecture & skill enhancement
- 50 minutes art and poetry exercises
- 5 minutes relaxation exercises (optional)

Sessions 5-8

- 15 minutes “check in”
- 70 minutes commemoration & violent dying retelling  
art and poetry exercises if time permits
- 5 minutes relaxation exercises (optional)

Session 9-10

- 15 minutes “check in”
- 75 minutes Reinforcing support & resilience after release  
FAREWELL exercise

The initial “check in” promotes an inclusive opportunity for each member to focus on the weekly changes in the thoughts and feelings associated with the violent death experience.

The “lessons” during the first four sessions are for the clarification and progressive reinforcement of skills to prepare for the imaginal exercises (re-exposure):

- ◇ Session One- Resilience (self-stabilization)
- ◇ Session Two- Restorative Retelling (living “story” > dying “story”)
- ◇ Session Three- Restorative Reconnection (imaginary reunion and conversation with deceased)
- ◇ Session Four- a place for yourself in the retelling (finding a role for the teller)

The poetry and drawing exercises promote an external expression of the commemorative and dying experience.

The imaginal exercises of commemoration and violent dying during sessions 5,6,7 & 8 allow a restorative retelling.

The last two sessions focus on identifying and consolidating the changes promoted by RR (and reinforcing their utility after release) with the final session celebrating the group termination over a farewell meal.

## **SESSION CONTENT**

**RR** is not a “standardized” intervention that follows a precise protocol for each session. Every member and group presents its own particular needs. Co-leaders are encouraged to assume flexibility in creating and presenting their own lessons and exercises. However, the ordering of the sessions – from **resilience to restoration to re-exposure** – is important to observe as the restorative retelling evolves.

The content of each lesson and exercise is brief and simple because of the brevity and limitation of **RR**. These lessons are presented here in a conversational format so the reader can better appreciate

the tone and style of the presentation. We do not want the co-leaders to memorize or read these lessons aloud to the group. Each co-leader spontaneously follows their personal conversational style.

The lessons are designed for group interaction -- for stimulation of discussion rather than a formal lecture.

## Session One RESILIENCE

◇ Introduction of the co-leaders

◇ Confidentiality and Safety:

With adolescents this can be such a salient concern that the entire group joins in a group exercise to compose a list of non-acceptable behaviors. This list can be posted and referred to in subsequent sessions should those behaviors occur.

Adult members usually arrive at a similar understanding of limitations without a formal exercise.

◇ Check in:

*“Welcome to this, our first of ten sessions. You all know that you are here because you have asked for help after the violent death of a family member or a close friend. Every session starts with a check in so we have a chance to hear how the week has gone for you. Since we are here to reduce your distress about the death, we want to be reminded of the name of the person you have lost – and what thoughts or feelings you have had about their dying. That’s what we need to check on so we know if we are making progress.”*

*“Since this is our first session, let’s begin by each of you introducing yourself and the name of the person who died – and tell us as much about their death as you want. We want to know what effect the death has had on you?”*

**After this group introduction, one of the co-leaders might begin by referring to the stories already told by the members.**

*“I appreciate your willingness to begin telling us these painful stories, and the courage it takes to start. When someone we love dies violently, we can never forget it. It changes us forever – so don’t think it’s unusual that these stories are still painful even though the deaths were years ago.*

*Whenever I first hear the story of a violent death it is difficult to listen because it stirs so many feelings and leaves me with so many questions. But that happens with all of us after a violent death – we try to make sense out of what happened and we can’t find an answer because it makes no sense.”*

*“So we are not here to give you answers—instead, we have to find a way to live with a dying that makes no sense. And often we are left with stories about the dying, (we imagine what happened, over and over) and there are stories about ourselves – that we should have prevented the dying from happening, that we have to get even by retaliating, that we could have rescued the person from the dying or we need to protect anyone else that we love from dying this way. Those stories can bring strong feelings of horror, helplessness, sadness, guilt, shame or dread. That’s what we need to help you with – the stories and feelings that you’re left with after the violent death.”*

*“Now, tell me how the rest of you felt about the stories you have heard from each other?”*

**After sufficient discussion, the co-leader can talk more specifically about resilience.**

*“I think it is important to understand what helped you cope with the violent dying. Each of us has to draw strength from somewhere when everything seems to go out of control. We need to be able to stay calm and know that we are going to be safe and can survive what has happened to us. Without feeling calm, safe and confident, it is hard to stay hopeful. We would all fall apart without it. I know that almost all of you used drugs or alcohol, and that only creates a false sense of calmness, safety, confidence and hope. How did you find that strength in yourself and your surroundings before you started using?”*

**After sufficient discussion, the co-leaders can lead an exercise on resilience.**

*“Now we are going to pass out paper and colored pencils, and we want each of you to spend the next 15 or 20 minutes making a drawing of the memory of someone or something that gives you a sense of calmness, safety, self-respect, confidence and hope. Maybe it started with someone in your family, or with friends, or a teacher – it could be anyone from your life. And sometimes it doesn’t come from people, but from a pet or a hobby or a special place, and finally, it can come from some spiritual belief. Maybe it comes from something I haven’t mentioned. And don’t worry about being a good artist. We are interested in what the image says about you, not how it looks – and we will have time for you to explain it to us.”*



**After completing the drawings, each member presents their image of resiliency to the group. The co-leaders collect these drawings for future reference.**

*“Many thanks to all of you. I always look forward to this exercise because it tells me what has been of help to you in the past when you’ve been distressed and we need to remind you of that strength as we work together. Now, before we end with a relaxation exercise, I want to check in with each of you again. How is each of you feeling about the group?”*

**This is an opportunity for the group to support a member’s early resistance, and for the co-leader’s assurance that everyone is committed to attending.**

The relaxation exercise can now be introduced as a strategy for self-calming and resilience.

## Session Two

### RESTORATIVE RETELLING

◇ Check in

*“Welcome to this, our second of ten sessions. Let’s start with a report from each of you about your progress since we met last week. Please remind us of the name of the person who died and any changes in your distress about the violent dying -- the thoughts, feelings, dreams or stories that you’ve been telling yourself.”*

**After the check in, the co-leader might use a report of diminished distress to introduce the clarification of restoration.**

*“Jeff, I am glad to hear that you were looking forward to coming back to group, and you’ve noticed that you’re not as torn up about the dying and can talk to others about it. But I think that what may have helped as much as the talking, is your beginning to remember your buddy, Alex, before he died.*

*Just talking about violent dying isn’t going to help any of us. Most of you have been doing that in your own mind for a long time. That reenactment story of the dying is hard to forget – and so are the stories we tell ourselves afterward – that we are somehow to blame because we should have protected them, or we need to get even, or we need to protect everyone else who we love.*

*Perhaps you need to talk about that person’s living memory as much as you think about their dying. We need to help you celebrate who Alex was and what sort of friends you were to each other. It sounds like that friendship was an important source of strength for you and I wouldn’t want you to lose that memory.”*

*“That’s what getting better is all about – remembering the person and the good times more than the bad times and the dying. It’s the story of the dying and the stories of yourself afterward that hang you up because they push you away from the memory of Alex when he was alive. If you stay stuck on his dying, or your remorse or your retaliation or your shame – it’s hard to go on because*

*all those stories lead nowhere. Alex would want you to remember him more for his living than his dying, wouldn't he?"*

*"So, we need to help you tell a fuller story of Alex than just his dying. I'm not telling you to forget his dying because you won't, but we need to know more about his life story before we know about his death story. We have a special session for his dying later. Now we need to help you tell the story of his living. It sounds like he was a very special person."*

**This sort of introduction can serve as a basis for Jeff and the other group members to discuss the living narrative of the deceased before the dying. As the discussion proceeds, it leads to the next exercise.**

*"It's time to put some of these living and dying memories on paper. There are actually two exercises for you, one with poetry and the other with words, that you can work on to prepare for the commemoration sessions 5 and 6. During those sessions you bring your loved one's life to us through pictures and words. You need some time and exercises to prepare for that."*

*"Try not to be self-conscious about your drawing or writing. We are not here as your judges -- this is a powerful way to tell your story from the heart and that's what we are trying to help you express -- your honest thoughts and feelings. So, go to work and we are here to help you."*

**The co-leaders can assist members in small groups or individually. They can take dictation if the member cannot write and guide members in drawing if they are unable to start.**

The co-leaders collect the drawings and poetry and the group ends with a relaxation exercise.

## Session Three

### RESTORATIVE RECONNECTION

◇ Check In

*“Welcome to this, the third of ten sessions – that means that we only have seven left. We want to hear from each of you about changes you have noticed in your memories of the person who died violently. Remind us of their name, and tell us what has changed in your level of distress – or your thoughts, dreams and feelings about the person.”*

**After the check-in, the co-leader might build upon several of the member’s reports to further clarify the next principle -- reconnection. Let’s use Jeff, again, to illustrate how the co-leader might develop reconnection on Jeff’s previous report of restoration.**

*“Jeff, it sounds as if you can remember more of Alex when the two of you were having good times together. It sounds like you were best friends (**with other relationships it may have been lovers or soul mates or protector – or with a family member it may have been caregiver or supporter or confidante**). It’s hard to have someone like that die. Violent dying is going on around us every day, but it doesn’t touch us very deeply unless we were close to the person who was killed. It hurts because we cared for them, and they cared for us. None of us can afford to lose that sort of caring connection – especially if you don’t let many people get close to you. Many of us miss that closeness so much that we keep imagining that they are still with us – and we look for their face when we are in a crowd, or listen for their voice – and most of us carry on an imaginary conversation with that person even though they died.”*

*“Do any of the rest of you miss that connection and even imagine talking to the person who died? What do you say to one another?”*

**This opens a discussion of the imaginary reconnection with the deceased after a violent death with Jeff and the other members. Once the group acknowledges the commonality of imaginary reconnection, the co-leader might use one member’s comments as a guide for the next exercise that externalizes the reconnection and draws support from it.**

*“What sort of thoughts, feelings, values and experiences still hold you and Alex together, Jeff? How would Alex try to take care of you – now that you are in here, and sitting in this group trying to adjust to his death? I doubt that he would want you to use drugs, or get into more trouble by retaliating or kicking ass, and I don’t believe that he would want you to feel so much shame and guilt for not protecting him. What would he tell us that you needed so he can help us get you better – and how would he help you after you left here?”*

*“In the next exercises, I want you to draw and write how you imagine Alex would help you if he were with us right now.”*

**Again, the co-leaders are available to assist members in the writing and drawing exercises.**

The co-leaders collect the drawings and writings and finish with a relaxation exercise.

## Session Four

### A PLACE FOR YOURSELF IN RETELLING

◇ Check in

*“Welcome to this, our fourth of ten sessions – that means we have only six left. We want to hear from each of you about changes you have noticed in your memories of the person who died violently. Remind us of their name, and tell us what has changed in your level of distress – or your thoughts, dreams and feelings about the person.”*

**As members report their progress, the co-leader reinforces the return of and reconnection with living memories of the deceased, and now introduces the open consideration of the violent dying imagery that group members are progressively more prepared to confront and retell.**

*“Jeff, you said that that for the first time since Alex died you had a different dream about him. Instead of the repeated dream about his dying and calling out for your help, you dreamed that the two of you met and he was healthy and glad to see you. I can understand why you felt sadness when you woke up – because he’s only there in a dream – but that’s very different than waking up in a panic because he’s dying and you can’t stop it. We can’t know precisely what any dream means, but I wonder if it suggests that you are allowing yourself to connect with his living memory and your own sadness? What do you think?”*

**As Jeff responds, the co-leaders can draw other members into the discussion by asking for their interpretation of Jeff’s dream, and the sharing of similar shifts in their traumatic imagery. The dream is cited here as an illustration – the reconnecting image can come from many other “reconnecting” experiences.**

*“Jeff, how can we help you to reconnect with the happiness and safety that you remember with Alex, at the same time that you remember his dying? The image that most of us have of violent dying is unreal because we weren’t there when it was happening – or if we were, there was nothing we could do to stop it from happening. Because of our powerlessness to stop it from happening, we can’t be in the dying story we tell ourselves – it’s like we have to witness it. The story doesn’t belong to us, because we can’t*

*find a place for ourselves in it. When we help you retell Alex's dying story, it is a much fuller story of Alex and you if you allow some time and space for you in story as you tell it. That way you can know that you are safe and are going save and reconnect with the good memories that you and Alex formed together. Where do wish you could have been in that story? What do you wish you could have done, or said before it happened?"*

*"Do the rest of you understand what I am saying?"*

**After Jeff and the other group members engage in a longer discussion of maintaining a sense of resilience and self-efficacy while retelling violent dying, the co-leader can introduce the next exercises.**

*"In the next exercise, we want you to draw and write about the dying story that you keep seeing and telling yourself. But as you draw or write, we want you to put yourself in the story – almost all of you were not there at the time of the dying. Where would you be? Create a place and a role for yourself in the dying story. There might be more than one picture or writing– that's O.K. We also want you to write a description so we can help you put words to what happened – and to be able to say things that you never had a chance to say to your friend or family member as they were dying without you."*

**Again, the co-leaders assist the members with their drawing and writing.**

Since only half of the group members present their commemorative imagery the next session, the co-leader asks for half the group to volunteer to present their work – and reminds them to prepare themselves with a decision regarding what drawings and writings they want to share. They need to know that there is a limitation of time – they will each have about 15 minutes to “celebrate” the life of their deceased through pictures and words.

The co-leaders collect the drawings and writings and finish with a relaxation exercise.

**Session Five**  
**COMMEMORATION RETOLD**

◇ Check in

*“Welcome to this, our fifth session – we only have five left. As always, we want to hear from each of you about changes you have noticed in your memories of the person who died violently. Remind us of their name, and tell us what has changed in your level of distress – or your thoughts, dreams and feelings about the person.”*

**As the members report on the changes in death related experience, the co-leaders now assume a less active role, anticipating that the members are secure enough in the group process and sufficiently involved in their own retelling, that they can enact their own restorative retelling.**

*“Today we begin a different sort of session. Instead of the co-leaders leading the discussion, it’s time for each of you to lead us through the story of the life of the person who died. We have over an hour for the presentations. That means that each of you will have    ? minutes. We will keep time and remind you when you have five minutes left so we make sure that each presentation can be completed. Who wants to start?”*

**The co-leaders may interrupt the presentation to include the involvement of other members (so the presenter is not isolated in the retelling) and asks that all drawings be passed around the group so every one has an opportunity to ask questions or add insights.**

*“Jeff, how does it feel for you to go through this time of commemorating Alex’s life with all of us? Is there anything that Alex would want you to add? How would he feel about your doing this for him?”*

**At the end of this round of commemorative presentations, the group cohesion increases as members are able to express their vulnerability and sadness more openly. These sessions are often very warm and emotive with the release of suppressed separation distress.**



If the presentations are abbreviated and do not fill the available time, group members can continue to work on their poetry and drawings or an additional group exercise on commemoration can be added.

The co-leaders collect the materials and finish the group with a relaxation exercise.

## Session Six

### COMMEMORATION RETOLD – continued

◇ Check in

*“Welcome to this our sixth of ten sessions – we only have four left. As always, we want to hear from each of you about changes you have noticed in your memories of the person who died violently. Remind us of their name, and tell us what has changed in your level of distress – or your thoughts, dreams and feelings about the person.”*

This session follows a similar format and content of session 5 for commemorative retelling of the remaining group members.

The group members are reminded that session seven deals with retelling of the violent dying, and the co-leaders ask for half the members to volunteer and prepare their presentations.

The group ends with a relaxation exercise.

**Session Seven**  
**VIOLENT DYING RETOLD**

◇ Check in

*“Welcome to this our seventh of ten sessions – we only have three left. As always, we want to hear from each of you about changes you have noticed in your memories of the person who died violently. Remind us of their name, and tell us what has changed in your level of distress – or your thoughts, dreams and feelings about the person.”*

**After the check in, the co-leaders reinforce positive changes reported in thoughts and imagery, and then relinquishes leadership to the presenting members.**

*“Today we begin a different sort of session. It’s time for each of you to lead us through the story of the violent of the person who died. We have over an hour for the presentations. That means that each of you will have   ?   minutes. We will keep time and remind you when you have five minutes left to make sure that each presentation can be completed. Remember that we might interrupt you if you become too overwhelmed or isolated in the story you are retelling us. We want you to include the rest of us in your telling. Who wants to start?”*

**The co-leaders may interrupt the presentation to include the involvement of other members (so the presenter is not isolated in the retelling) and asks that all drawings be passed around the group so every one has an opportunity to ask questions or add insights.**

*“Jeff, I need to interrupt as you show us this frightening picture you have drawn. At least it’s outside you now. You’ve carried it inside you and now we can see it too. Alex being beaten to death is a horrible image. I think that I am feeling more than you will allow yourself to feel. I can hear your anger, but what about your sadness, and your guilt that you weren’t there to protect him. You are only allowing yourself one feeling – and I think all of us in the group can feel that anger, but I think that there is whole range of feelings that your drawing stirs in all of us. How about the rest of you – do you see and feel more than anger?”*

**That sort of interruption endorses and respects Jeff's response, but tries to widen and deepen the retelling of himself in the story – beyond his anger and need for retaliation -- to include feelings and thoughts that he can change. Jeff's raw anger and retaliation are unreflective acts, externally directed, and unchangeable. His obsession or enactment of rage and retaliation is intent on changing someone else (by hurting or killing) rather than processing and accommodating the thoughts and feelings that remain within him. Of course, the objective of “widening and deepening” the retelling might include anger and retaliation if all of the retelling was obsessed with remorse or rescue.**

**Each “interruption” is better received if it begins with affirmation and respect from the co-leader,** *“I can understand why you are thinking or feeling that way, but perhaps there are other thoughts and feelings that you aren't allowing yourself –and let us help you find them.”*

**Sometimes inmates show little feeling with violent dying imagery because of their defense of avoidance, i.e. they acknowledge the reality of the violent dying, but deny any feeling associated with the event. They often need to be prompted by other member's feelings before they are able to recognize those same feelings in themselves.**

*“Jeff, it's O.K. to cry – it's about time – and you've got half the group crying for you. I felt close to tears when saw where you put yourself in the drawing as Alex was dying – reaching out to be with him, so he wouldn't die all alone. He didn't have time to cry for his own death, so you have a double dose of tears – yours and his too.”*

If the presentations are abbreviated and do not fill the available time, group members can continue to work on their poetry and drawings or an additional group exercise on violent dying restoration can be added.

The co-leaders collect the materials and finish the group with a relaxation exercise.

## Session Eight

### VIOLENT DYING RETOLD – continued

◇ Check in

*“Welcome to this our eighth of ten sessions – we only have two left. As always, we want to hear from each of you about changes you have noticed in your memories of the person who died violently. Remind us of their name, and tell us what has changed in your level of distress – or your thoughts, dreams and feelings about the person.”*

This session follows a similar format and content of session 7, violent dying retelling, for the remaining group members.

The co-leaders collect the materials and finish the group with a relaxation exercise.

## Session Nine

### REINFORCEMENT OF RESTORATIVE RETELLING

◇ Check in

*“Welcome to the ninth of ten sessions – we have only one left. As always, we want to hear from each of you about changes you have noticed in your memories of the person who died violently. Remind us of their name, and tell us what has changed in your level of distress – or your thoughts, dreams and feelings about the person.”*

**After the check in, the co-leader begins to prepare the group for termination.**

*“I feel grateful to each of you for making this such a solid and meaningful group. You have worked hard to make changes in yourselves, and I want to remind you how much progress each one of you has made in such a short time.”*

**The co-leaders might “check out” each member as a reversal – to point out the changes they have observed over the 9 sessions in each member. This can be a highly reinforcing exercise “from” the co-leaders “to” each group member.**

**Now the co-leaders might emphasize the need for continued restoration.**

*“Most of you are more at peace with what happened. But we told you at the beginning that none of you can be “cured” – that violent dying will always be painful, even though it won’t haunt your mind as often as it did when you started group.”*

*“In this session we want to strengthen the gains that you have made so you can continue to build on them while you are here and after you are released. We need to hear from you, what have you learned about yourself and the violent death that you want to work on? And who can you turn to for more help?”*

*“What can you do for yourself if the thoughts and dreams of the dying come back. We want to make a plan of action for self-care after you leave us.”*

**The co-leaders begin an exercise to reinforce restorative retelling by eliciting and recording a list of restorative activities and resources – as a basis or ingredients for restorative retelling to be passed out to the members at the last session.**

*“Next week will be our tenth, and last session. We want to give each of you the opportunity to tell us what this group has meant to you, and how you feel about it ending. Who wants to start?”*

**This gives each member a time to communicate their thoughts and feelings of separation from people who have listened and helped to retell their dying story – they have become a part of the “story” as well, and the termination and separation from the group can now be expressed. Most inmates have had few opportunities to retell a “story” or separate from a close relationship with a positive and valued ending, so this ritual of saying goodbye to the group is sometimes filled with awkward and unpracticed efforts to thank one another. Of course, it also represents an indirect relinquishment of the dying story. Though the dying story continues to be privately retold after termination, the group can no longer play a supportive role in it, and there is often an anticipatory sadness about the loss of group support.**

## Session Ten

### FAREWELL

#### ◇ Check in

*“Welcome to our last session. We want to hear from each of you about changes you have noticed in your memories of the person who died violently. Remind us of their name, and tell us what has changed in your level of distress – or your thoughts, dreams and feelings about the person. This last time we want you to add what you imagine your friend or family member who died violently would say to you and the rest of the group about changes that they have noticed. Let’s give them an opportunity to say goodbye too.”*

**This farewell exercise includes the restorative message from the deceased in the separation preparation – as a voice of support and hope.**

*“Let’s review the Restorative Retelling check list that the group composed last week. Now you can leave with a written reminder of what strategies can help you with the violent dying story after the group.”*

**This exercise is a further reinforcement of strategies to enhance resilience, restoration and re-exposure that group members can continue to practice and enact.**

*“ Finally, we want the group to join in a written exercise of farewell. We will pass out cards (3” by 5” cards) to you, and we want you to write a good bye message to each member of the group – including us, the co-leaders -- and we will fill out cards too.”*

**After the cards are filled out, distributed, and read aloud, the group shares a celebratory meal or snack (pizza or cake and ice cream – whatever is appropriate for the group members and institution).**



### **Repeat Self-Report Measures:**

If the group members have filled out self-report measures before the sessions began, this is an opportunity to repeat the tests – and the group remains to finish the measures before leaving. The co-leaders offer to meet with the group for a follow up session in a month's time so that each member can review the pre/post changes in their own measures. This allows a further reinforcement of change and a “giving” of the measures back to each of the group members for feedback.

### **Co-leaders Characteristics and Experience:**

Since **RR** is a voluntary, supportive, self-monitored, re-exposure technique, it can be viewed as instructional rather than a formal treatment. Viewed from this perspective, the co-leaders function as “clarifiers and guides” in retelling the traumatic story of a violent dying memory. They are not therapists who assume primary clinical responsibility for the treatment of a defined psychiatric disorder. Instead, **RR** encourages and then reinforces a more “normative” and spontaneous manner of retelling that was difficult for inmates to initiate – usually because of multiple pre-existent traumas and active chemical dependency.

Together, the co-leaders require the combination of the following skills:

- 1) Enough diagnostic acuity to carry out an active screening and assessment for co-morbidity.*
- 2) Enough group therapy experience to have competence in initiating, reinforcing and restoring group cohesion.*
- 3) A competence with techniques of stress management and graduated exposure.*
- 4) A competence in managing the monitoring of individual progress, or lack of progress, within the format and goals of a short-term group intervention – which requires a high level of organizational skills and direction.*

This combination of capacities and skills can be found in any level of mental health worker training (psychiatrist, psychologist, social worker or counselor).

Mental health workers in correctional facilities have had abundant clinical experience with trauma and separation distress related to violent dying, and are well suited to serve as co-leaders of **RR**.

### **Co-leaders Training:**

**RR** has been taught to mental health workers in the community (and, recently, within correctional facilities) through brief training workshops leading to its successful replication. Since **RR** is such a relatively simple and intuitive reprocessing of a traumatic story, it is presumed that most mental health workers need little instruction beyond an agenda and manual. **RR** is so novel and unstudied that there is insufficient data to validate its longer-term effects. It would be presumptuous to offer rigorous training, supervision standards and guidelines until a controlled, prospective study verifies its positive effects.

This manual is designed to provide sufficient information and instruction to allow motivated co-leaders to begin their own **RR** intervention without formal training. Mental health workers in correctional facilities have usually had requisite training in the elements of **RR** (resilience, restoration and re-exposure) so that they do not require instruction beyond a written description.

Consultation and training workshops are available and can be requested by the co-leaders or correctional facility administration, but that is not a pre-condition for its use.

### **Co-leaders Supervision:**

Co-leaders need a 30-minute time following each group to review (1) the progress of the group, and (2) the progress of each individual member. These discussions might lead to corrective adjustments to increase group cohesion, reinforce resilience in an individual member, or to discuss disruptive behavior.

It is particularly helpful to have a senior staff member to serve as a “consultant” with whom co-leaders can meet to review progress – and to have “on call” for review of a highly disruptive member who may need to be transferred from the group to another resource of support. That is a rare occurrence, but a protocol for consultation in that decision-making is helpful.

The weekly self-review of group members provides a tangible self-monitoring of **RR** progress, and the review of pre/post changes on standardized measures at the end of the group provides a reliable measurement of response. Since the purpose of **RR** is primarily instructional, and the monitoring of

progress in individual response is contained in the **RR** format, frequent external supervision is not indicated.

Like any other intervention, it is important for the co-leaders and mental health director of the facility to review the efficacy and utility of **RR** after sufficient data and follow-up are gathered.

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## **APPENDIX**

In this section we include drawing and writing exercises. Some group members prefer writing over drawing – or drawing over writing – and they should be encouraged to work in whatever style suits their own needs. Some members want to complete all of the exercises and others might use several or introduce their own aides to retelling beyond the exercises.

As with the agenda, the exercises are presented as a guide rather than a rigid protocol. Do not anticipate or insist that each member complete each exercise.

We also include a list of questions to better structure the drawing exercises.

We have presented each exercise on separate pages so they can be copied and used as handed outs.

## **RESILIENCE (drawing)**

### **Session One**

**You have told us the stories of how your loved one died and how you've been affected, and we've all had a chance to become acquainted with the group and each other. Now we'd like to ask you to think of someone, some place, or some thing that gives you a feeling of calmness. This is a loving, peaceful, hopeful person or place, somewhere you feel safe and respected.**

**We'll take about 15 minutes for you to remember and draw who or where or what this was or is for you. Draw, as best you can. Don't worry about whether you're an artist; just put on paper what comes to you.**

**Here are some questions that might help you start:**

- 1. Where is this place?**
- 2. When were you there?**
- 3. Who's there? How is this person (people) special to you?**
- 4. What's happening?**
- 5. How do you feel with this person? In this place?**
- 6. What things are there?**
- 7. How are these things special to you?**
- 8. Where are you?**

## **RESTORATIVE RETELLING (drawing)**

### **Session Two**

#### *Celebrate your loved one's living*

**We'd like you to help us know more about your loved one before she/she died. What made him/her special to you? Would you draw images of those memories? Tell us the story of your loved one's life.**

**Here are some questions that might help you get started:**

**Who was the special person you lost?**

**What was his/her name?**

**How old was he/she?**

**Appearance:** What did he/she look like? Is there anything special you remember about how he/she dressed? Wore his/her hair? Describe his/her face.

**Where did he/she live?** Describe the house or a room or the apartment. Where was your favorite place there?

**What did he/she like to do?** Hobbies? Sports? Music he/she liked? Arts? Favorite TV? How did he/she spend their time off? What was his/her work?

**Where were some of his/her favorite places to be or to go?**

**What did you like to do with him/her? Where did you like to go together?**

**What did you learn from this person?**

**How has your life been affected by this person?**

**What do you want us to remember about your loved one?**

## **RESTORATIVE RECONNECTION (drawing)**

### **Session Three**

**Imagine that your loved one is with you right now. Imagine that your loved one knows what you're feeling and going through as you try to adjust to his/her dying. As these thoughts come to you, draw images you can share with us.**

**Here are some questions that might help you start:**

- 1. What would your loved one want for you now?**
- 2. How would your loved one help you?**
- 3. What would your loved one want to tell us you need?**
- 4. If your loved one were here with you right now, imagine what he/she would do to help you.**



## **A PLACE FOR YOURSELF IN RETELLING (drawing)**

### **Session Four**

**This time we're going to ask you to draw what you actually saw or what you imagine happened in the last moments of your loved one's life. What do you see, over and over, in nightmares or flashbacks or when you think about what happened? And we want you to place yourself in the drawing – even if you weren't there. Where do you wish you could have been as they were dying? – what would you have done or said?**

**By drawing and talking -- what you've seen or imagined will become more real. Then we can all share some of what you've been carrying by yourself.**

**Think about the following as you do the drawing:**

- 1. Were you there at the scene, or shortly afterward, or did some period of time go by before you heard your loved one had died?**
- 2. What did you see or imagine happened in the last moments before your loved one died?**
- 3. Who was there? Where would you put yourself – if you could have been there?**
- 4. Where did this happen? Describe the scene.**
- 5. About what time of the day or night was it? What time of the year was it?**
- 6. What do you imagine your loved one was saying and feeling?**

## **COMMEMORATION (drawing)**

### **Sessions Five and Six**

**Group members normally require little if any guidance in their commemorative drawings and pictures.**

**Some group members have such difficulty in sharing their drawing, that their commemorative presentation can be more structured by their providing answers to the following questions:**

**Who was the special person you lost?**

**What was his/her name?**

**How old was he/she?**

**Appearance:** What did he/she look like? Is there anything special you remember about how he/she dressed? Wore his/her hair? Describe his/her face.

**Where did he/she live?** Describe this place. Describe the house or a room or the apartment. Where was your favorite place there?

**What did he/she like to do?** Hobbies? Sports? Music he/she liked? Arts? Favorite TV? How did he/she spend their time off? What was his/her work?

**What were some of his/her favorite things to eat?**

**Where were some of his/her favorite places to be or to go?**

**What did you like to do with him/her? Where did you like to go together?**

**What did you learn from this person?**

**How has your life been affected by this person?**

**What do you want us to remember about your loved one?**

## **VIOLENT DYING RETOLD (drawing)**

### **Sessions Seven and Eight**

**Group members normally require little, if any, guidance in presenting their violent dying drawings.**

**However, some group members have difficulty -- and their presentation can become more coherent for them if they are allowed to answer a series of direct questions:**

**Answer the following as you tell us about the drawing:**

**What was your loved one's name?**

**Tell us about what happened in the last moments before your loved one died?**

**Who's in your drawing?**

**Where did this happen? Describe the scene.**

**Do you imagine your loved one was saying anything?**

**What do you imagine your loved one was feeling?**

**If you could've been there, in this drawing, where would you put yourself?**

**What do you wish you could've done?**

**What do you wish you could've said?**

**What was it like for you to do this drawing?**

**Techniques to Facilitate Therapeutic Writing  
for Restorative Retelling within a Correctional Setting**

by Richard Gold

Writing is a powerful tool for healing after a violent death. It enables people to externalize, make concrete, and integrate feelings and traumatic images. Fortunately many people in Restorative Retelling groups feel a natural desire to express themselves and help themselves in this way. But for others, including a high percentage of incarcerated adolescents, the desire to express themselves is impeded by fear, mistrust, insecurity, and poor conceptual and language skills. These group members benefit from techniques that encourage and structure the writing experience.

To help people into the creative and therapeutic process, it's important for group leaders to welcome writing and to respond to it attentively, respectfully, and uncritically. It's useful to encourage people to bring in writing they've created in the past and outside group. It's important to assure people that emotional honesty is the most important quality of their creative work, and not correct spelling and grammar. Honoring people's writing, by typing, posting, saving, and publishing it, is very useful for creating an open environment of trust and mutual respect. When authors read their writing aloud (or permit a group leader to read their writing aloud), it rewards and facilitates everyone's emotional work in the group, and becomes a source of group pride and cohesion.

One of the biggest challenges for a leader is to help everyone in a writing group contribute comfortably, even group members who are reserved or who possess limited language skills. The way to meet this challenge is to provide a structure that guides people into self-expression, yet gives them latitude to express themselves at the level of their ability. For example, while it's harder for every person to "write about your mother" on a blank piece of paper, it's easier to fill in blanks next to a list of physical attributes ("hair" "eyes" "voice") printed on a page. The printed list still facilitates self-expression and risk-taking. The difference is that while some people will

express themselves with a poem about each attribute, others can now write a one-word response that is meaningful to them (“brown” “bright” “loud”).

Taking dictation is often the best approach for working with certain quiet, insecure, or confused individuals, even within a flexibly structured writing activity. A leader can sit down with one group member while others are working on their own, and record the person’s oral poems or verbal responses to an activity. And when mere recording is not help enough, a leader can jump in collaboratively, by offering models and suggestions: “Was your mother’s hair short or long, black or brown or blond, any gray, straight or curly? Was your mom proud of her hair? Did she like hats?”

Another structural choice that a group leader can make, to facilitate full and comfortable participation in writing, is to use collaborative group exercises as well as independent individual ones. While participants can’t work as a group on certain tasks (such as imagining a letter to a specific person in their life whom they’ve lost), they can work as a group on lists of feelings they’ve experienced in reaction to that loss (“I felt angry because..., I felt lonely because...”). The group leader stands in front of everyone, helping the discussion along and recording contributions on a board or large pad. An energized group that is sharing ideas and experiences to create a piece of writing will often move naturally into a significant dialog about shared pain.

An important structural technique to mention here is that writing activities should follow the thematic progression of Restorative Retelling. They should begin with activities that support the participants by allowing them to write about their strengths of knowledge, experience, and feeling. (An example is the exercise that follows: “The Things I’d Like to Understand.”) Then the activities should enable participants to reconnect with those they’ve lost, through memories, description, and dialog. (An example is the exercise “What A Friend Might Say.”) Next the activities should allow participants to describe death imagery and say goodbye to their loved ones. (An example is the exercise “When Death Comes Suddenly.”) Finally the activities should allow participants to look forward, into the future, and develop a changed relationship to their grief. (An example is the exercise “Letter After a Time.”) On the last day of group, a good wrap-up activity is to ask group members to express goodbyes and wishes to one another in private notes on cards.

Because of the opportunity for expression, support, revelation, connection, and healing, therapeutic writing is a useful way for group leaders to engage participants in Restorative Retelling. Part of the pleasure for therapists can be the challenge to the group leader's own creativity. We wish you success in this work. Permission is granted for licensed therapists to copy and use the writing exercises that follow in this manual, (but please note that the exercises are copyrighted and cannot legally be changed, reproduced for other purposes, or republished). Therapists are also invited to email us with comments and questions.







**IF YOU HADN'T DIED**

I imagine you still

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I imagine some changes

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I imagine us together

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I imagine...

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I imagine there'd be difficult times

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I imagine our feelings

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I imagine...

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I imagine my life

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I imagine a regret

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I imagine a hope

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I imagine...

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HEART LIKE AN ENGINE

Powerful when \_\_\_\_\_

\_\_\_\_\_

Clogged when \_\_\_\_\_

\_\_\_\_\_

Efficient when \_\_\_\_\_

\_\_\_\_\_

Sputtering when \_\_\_\_\_

\_\_\_\_\_

Purring when \_\_\_\_\_

\_\_\_\_\_

Frozen when \_\_\_\_\_

\_\_\_\_\_

Clean when \_\_\_\_\_

\_\_\_\_\_

Choking when \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ when (Choose your own word or one of the following: Smooth-running, Racing, Burning, Roaring, Stalled, Broken down) \_\_\_\_\_

\_\_\_\_\_