

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 will serve as a consultative resource for trainers, researchers and providers by providing contact information regarding 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 world wide, 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 than 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 drop out 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 studies of adolescents and adults grief stricken following violent dying which include outcome studies 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 less than 5% 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 police and media reports, exaggerated and 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 or weeks after the death.

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

- 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 during the first days and weeks of traumatic grief, but with the support of family and friends and through the finality of the memorial service and funeral, the memory of the violent dying and its storied reprocessing begin to fade. Most family members and loved ones are able to accommodate by engaging in a spontaneous restorative retelling and meaningful rituals and commemoration of the deceased with family, friends and community. The story of the life of the victim gains ascendancy and becomes stronger than the story of their dying.

If the violent dying was a terrorist attack, a homicide or accident, the media, police and the court are also involved in retelling the dying. These retellings clarify the dying act, and attempt 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.

Trauma and Separation Distress to Violent Dying

Our 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 will diminish the distress responses of trauma and separation.

Intervention first focuses on strategies to restore resilience, then exercises to retell and commemorate 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 an open trial outcome study in 64 adult subjects who sought and completed time-limited group intervention for distress secondary to violent death at one of two sites (Seattle or San Diego) from 1999 through 2000.

Preparatory to a controlled outcome study, this study was 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** – (description)
- **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,

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 – 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 demographic data describe the 64 subjects as predominantly Caucasian (68.3% White, 18.7% Hispanic, 10.3% African American, 6.9% Asian), female (73%), adults (mean age 42.9 years) who were well educated (63% college graduates), and reported a high frequency of previous mental health treatment (29.6%) and psychiatric diagnosis (25.4%). Nearly all (98%) were related to the deceased (29.6% parent of deceased child, 24.1% child of deceased parent, 14.8% sibling, 7.4% spouse, 13.0% other). The majority of the violent deaths were homicidal (68.3% homicide, 15.9% suicide, 15.9% accident).

The subjects began intervention soon after the violent death (median: 6.3 months). The interval between pre and post self-report measures was 3.6 months. Nearly two-thirds (65.6%) of the subjects were enrolled in the RR intervention because that intervention included subjects after a violent death related to suicide or accident as well as homicide.

Table 1 contains the mean scores and statistical analyses comparing the self-report measures before and after the interventions. The mean scores of the BDI, DIS, CGA and RIES-R before intervention were elevated, suggesting a high level of generalized distress. The DAST score was below the cutoff score (< 8.0). The data show a highly significant ($p < 0.05$ to 0.0001) decrease on all measures of distress coincident with the interventions. The DAST remained low before and after the interventions.

Table 1. Outcome summary scores: Pre and Post means.

Sum Variable	Pre Mean (SD)	Post Mean (SD)	t or χ^2	
BDI ^a	19.4 (11.3)	15.5 (10.5)	-3.45	**
DIS ^b	7.4 (5.2)	5.7 (4.7)	-2.95	**
Reenactment	2.8 (2.0)	2.1 (1.8)	-3.36	**
Rescue	1.5 (1.8)	1.0 (1.5)	-1.65	
Revenge	1.5 (1.8)	1.0 (1.4)	-1.18	
Reunion	2.0 (1.7)	1.7 (1.7)	-1.20	
ITG Diagnosis ^c	24.6 %	13.1 %	6.00	*
ITG ^d	35.3 (14.0)	29.6 (14.8)	-4.51	****
RIES Total ^e	38.3 (13.6)	28.7 (16.5)	-5.32	****
Avoidance	15.8 (8.2)	11.1 (8.5)	-4.57	****
Intrusion	22.5 (8.7)	17.6 (9.9)	-4.24	****

[†] $P < 0.10$; * $P < 0.05$; ** $P < 0.01$; *** $P < 0.001$; **** $P < 0.0001$; two-tailed.

Values of $p < 0.05$ indicate that there is a significant difference between the Pre and Post means.

^a BDI = Beck Depression Inventory, a 22-item scale; summary score ranges from 0 to 66.

^b DIS = Death Imagery Scale is made up of four items (reenactment, rescue, revenge, and reunion), each ranging from 0 to 5; summary score ranges from 0 to 20.

^c Traumatic Grief (TG) diagnosis was calculated using the diagnostic algorithm of the Inventory of Traumatic Grief (ITG)

^d ITG = Inventory of Complicated Grief, an 18-item scale; summary score ranges from 0 to 72.

^e IES-R = Revised Impact of Events Scale, a 15-item scale (summary score ranges from 0 to 75), made up of a 7-item Intrusion subscale (summary score ranges from 0 to 35) and an 8-item Avoidance subscale (summary score ranges from 0 to 40).

^f DAST = Drug/Alcohol Screening Test, a 32-item scale; summary score ranges from 0 to 85.

Pearson correlation coefficients between outcome summary scores and loss characteristics

This pilot study demonstrated that participation in an open trial of short-term, group intervention in highly distressed subjects within the first year of the violent death of a loved one was 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 that these 64 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 study 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 drop out rate.

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

- **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 that the individual 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, hyperarousal) 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 "commemorative" sessions. This commemorative imagery serves 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 that 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, hyperarousal, 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

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

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 absent the significance 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 they 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.

Each session begins with a brief (5-minutes or less) individual “check in” for each member.

The member is 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.

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 commemorative imagery after the initial four sessions and before the death imagery sessions is a carefully designed aspect of the treatment. Commemorative imagery gives each group member an opportunity to focus on positive aspects of who the 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 three assignments members are asked to do for group.

- Commemorative presentation prepared by each member
- Drawing death imagery
- Family and Friends Session

RESTORATIVE RETELLING GROUP OUTLINE

GROUP ONE

1. ORGANIZATIONAL:

- Have name tags and markers available for group members at the beginning of each session until the group is comfortable remembering each other names.
- 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/feelings check-in (A facilitator will need to explain what this is.)

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: Ask the group who has had previous experience in group support. Reassure all that in this group no member will be put "on the hot seat." Also, acknowledge 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 unnatural death differs in its effects from the effects experienced after the natural death of family/friend.

- No goodbye; no resolution
- No time to adjust or make preparations
- Problem to understand/accept/process the unnatural 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 unnatural 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:

Tell us what happened. What's brought you to this group? Who have you lost, how, when?

NOTE: Members need reassurance that narrating what happened is a most difficult thing to do as will be listening to each other's accounts.

6. GROUP MEMBERS' RESPONSES TO EACH OTHER:

Facilitators might ask members if, having heard each other's accounts, anyone would like to respond to another member or add to what was said. It is helpful to ask, "How was it for you to talk about/to hear about what happened?"

Facilitators, somewhat familiar with each member's history from the initial interview, should look for connections at this time and might use them as ways to create early group interaction and cohesion.

The following are some examples of connections facilitators know or learn about during the narratives:

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?

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 an unnatural way, you may have little sense that you "feel" anything at all or that you only feel "bad" or "OK." The range of feelings you had may 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 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?"

Spiritual: What about your 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?

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 to identify any significant dates which will occur during the remaining sessions. This includes anniversaries, birthdays, anniversaries of death, and any other special dates. Note these carefully.

1. CONTENT:

- What is "co-morbidity"?
Prevalence of **DISEASE** or **ILLNESS** or **ILL HEALTH** that often goes along with "bereavement". This may include accidents, illness and disease.
Feelings of **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 are often co-morbid with loss due to unnatural causes.
- What is PTSD? (Panic attacks, flashbacks, re-enactment, active avoidance of reminders, terror, nightmares, intrusive thoughts).
- 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).
- Substance abuse
- Panic attacks
- 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".

Of significance also is the feeling of being **FROZEN** since the loss. 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 as unworthy as group members do oftentimes, they feel 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.

It is easy and tempting for facilitators to want to give advice. Group members will by this session sometimes reflect that they came to the group wanting and expecting to get answers: how to get over PTSD; how exactly to get over self-blame; to learn specific methods and tools or to be given assignments to stop feeling miserable and stuck.

If you feel someone is telling you, you aren't doing enough, aren't saying the right things, 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 group has this feeling. Sort it out. By now, you can use the group for this process.

Group members report they sometimes feel invisible, going through their days on the outside, observing everything and everyone without a sense of belonging or relating. The worst they could ever have imagined has happened. They no longer communicate, no longer seem to care – about anything. They may "look good" or "like everyone else," but they are not "seen." They may not WANT to be "seen."

It can be helpful to discuss how other cultures honor and "mark" people and share within their cultural traditions such significant losses. Where do our group members do this? With whom?

2. ORIENTATION TO COMMEMORATIVE IMAGERY/NARRATIVES

In order for the group to know more about the person you lost, we'll spend the next two sessions with commemorative imagery or narratives, where you present that person to us. You could 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.

Plan to take about 20 minutes each.

3. RELAXATION EXERCISE

GROUP FIVE:

COMMEMORATIVE

Check-In:

1. COMMEMORATIVE 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 around 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. Preparing for these presentations has helped members repair their sense of perspective. Sometimes members say they haven't thought about or looked at special things which belonged to the deceased because of the pain it caused them to feel. Or members may realize how 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 sort through them.

2. GROUP RESPONSES

3. RELAXATION EXERCISE

GROUP SIX:

COMMEMORATIVE

Check-in:

1. COMMEMORATIVE PRESENTATIONS
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 commemorative 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 commemorative 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 "associate" with instead of "dissociate" from 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 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.

4. RELAXATION EXERCISE

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 large pieces of paper to each member.
- 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

Check-in:

1. DEATH IMAGERY

Tell us about your drawing. What do you imagine the last thoughts were? Feelings? Behaviors?
What happened?

Where do you imagine yourself, if you'd been there?

What do you imagine yourself doing, if you'd been there?

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

Please introduce you family member/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)?

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 and (3) to confirm the mutually supportive nature of the continuing relationship.

Some examples may include:

- Holding hands in a circle
- Lighting a candle
- Moment of silence
- Saying “A Word” (Peace, Sharing, Love, Courage)

Facilitators may want to bring cookies and/or flowers or some other symbolic objects for the groups to use in their rituals.

GROUP TEN:

CONCLUSION

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

1. RITUAL: Materials you will need:

- Journals or craft material (paper, glue, scissors) for group members and facilitators
- Ballpoint Pens, color markers, crayons, etc.

Activity: Have group members and facilitators write a parting thought to each other about what touched them about that person.

Once complete, these writings are distributed. Members are encouraged to 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 and return them to the group leader so an objective comparison of their distress scores can be monitored. 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 their distress measures together as a group.

3. GOOD-BYES:

At the end of the ritual the facilitators and group members join into one circle. The following are some examples for the closing ritual.

Candle-lighting: The facilitator lights his/her candle and shares the flame with the person standing to his/her right. This is repeated by each person until everyone's candle has a light. The name of their loved can be spoken as their candle is lit.

Group hand-hug: One person begins by squeezing the hand of the person beside him/her. 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. This person then 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 relaxation 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 encourage 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 are made safe within the group as the facilitator maintains 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 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 Franks' four principles of group treatment which are: (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 which are 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 batteries. Keep in mind that your purpose is clinical, that you want to be sure that the group is appropriate and that this is a source of support which could be helpful 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. These limitations are accepted by members at the outset so that enforcement will be anticipated.

Members Who are Intoxicated: 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.

Drop-outs: 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 track 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 – Clinical Screening

SEPARATION AND LOSS SERVICES

Clinical Screening Instrument Scoring

E.K. Rynearson, M.D.

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Fanny Correa, M.S.W., C.T.

**Revised
July, 2008**

**Virginia Mason Medical Center
Seattle, WA
CLINICAL SCREENING BATTERY**

PURPOSE: *This battery has been developed primarily for clinical documentation, and secondarily for clinical research. Our main interest is in using the battery to inform the clinician and patient about the clinical status of those referred for assessment. The results of these tests may guide the clinician in recommending individual or family counseling or more specialized interventions ("Restorative Retelling").*

THE INSTRUMENTS:

Beck Depression Inventory (BDI):

The BDI has become one of the most widely accepted instruments in clinical psychology and psychiatry for assessing the intensity of depression in psychiatric patients and for detecting depression in normal populations. The 21 items are self-rated from 0 to 3 in terms of intensity.

Scoring:

The BDI is scored by summing the ratings given for each of the 21 items. Each item is rated on a 4-point scale ranging from 0 to 3. If an individual marks two ratings for the same item, use the higher of the two ratings. The maximum total score is 63.

Guidelines for Total Scores:

- 0-9: within normal range
- 10-18: mild-moderate depression
- 19-29: moderate to severe depression
- 30-63: extremely severe depression.

Clinical Implications:

Any **score >18** indicates the need for psychiatric consultation and consideration of psychotropic medication.

The median score for an adult family member 6 months after the violent death of a family member is 19.4 (submitted for publication).

Complicated Grief Assessment (CGA):

Developed by Holly Prigerson, Ph.D. and Paul K. Maciejewski, Ph.D.

There are 2 instruments (only select one) which may be used to assess complicated grief:

- 1) the self-reported assessment which contains 11 questions and,
- 2) a 3-part assessment completed by the clinician during the interview.

These instruments identify symptoms which comprise the range of thoughts and emotions which define complicated grief.

Clinical Implications:

Complicated grief is a risk factor highly associated with a number of serious physical health and behavior changes such as alcohol/drug abuse, suicidal ideation and increased blood pressure. The CGA addresses the synergism between traumatic grief and separation distress.

Impact of Event Scale – Revised (IES-R).

This instrument measures the severity of the impact of the loss experienced by an individual and indicates whether someone has a score which indicates caseness for PTSD. This self-report, 22-item instrument is made up of three subscales: Intrusion, Avoidance and Hyperarousal.

Clinical Implications:

Intrusive thoughts and imagery occur without warning, most often making the individual feel victimized and out of control. People suspect they're "going crazy" and are driven to seek treatment if this continues. Avoidance, on the other hand, is a more active, conscious "effort" on the survivor's part to control aversive, troubling thoughts and imagery. Thus, intrusion and avoidance are related but different.

Scoring:

Scores on the three subscales, taken together, are only indicative of PTSD. Instead of confirming a diagnosis, the scores inform the clinician and the client/patient and provide useful information about what “kind” trauma signs and symptoms an individual reports. For example, is the individual experiencing intrusion and hyperarousal symptoms, primarily, or some other combination, and what is the level of severity? Our recommendation is to score each subscale, sum these scores to obtain a cumulative score and thereby form a clinical judgment about the possibility of syndromal PTSD and use this as a basis for recommending various interventions or supportive services.

Item Response Anchors are: 0 = Not at all; 1 = A little bit; 2 = Moderately; 3 = Quite a bit; 4 = Extremely.

The **Intrusion** subscale is the **MEAN** item response of items 1, 2, 3, 6, 9, 14, 16, 20. Thus, scores can range from 0 through 4.

The **Avoidance** subscale is the **MEAN** item response of items 5, 7, 8, 11, 12, 13, 17, 22. Thus, scores can range from 0 through 4.

The **Hyperarousal** subscale is the **MEAN** item response of items 4, 10, 15, 18, 19, 21. Thus, scores can range from 0 through 4.

The median avoidance and intrusion score on adult family members 6 months after a violent death is 15.2 (avoidance) or 17.3 (intrusion) – we have not collected enough scores on hyperarousal to establish normative values.

Death Imagery Scale Revised, (DIS-R):

Developed by E.K. Rynearson, M.D., the DIS indicates the degree to which individuals experience identificatory reenactment imagery related to police and media reports, further embellished by the individual's projective fantasies, and in some cases, based on what the individual actually witnessed. Of the five types of imagery, reenactment showed the only significant difference between those individuals who sought treatment and those who were non-treatment seekers. Themes of rescue, reunion, revenge and remorse were statistically non-significant in differentiating treatment seekers from refusers.

Scoring:

Each item is scored 0, 1, 3 or 5 (0=none, 1=once/month, 3=once/week, 5=daily).

Rynearson's study found that treatment seekers experienced re-enactment imagery on a daily or weekly basis (score of 3 or 5) while other forms of death imagery (rescue, revenge, reunion, remorse) was less intense.

The median reenactment imagery score for an adult family member 6 months after a violent death is 2.8 while other forms of imagery score < 2.0 (submitted for publication).

Clinical Implications:

Be alert to adult family members **scoring 3 or 5 on DIS item #1, Reenactment**. If an individual reports that he or she experiences reenactment imagery to this degree, the clinician should consider recommending restorative retelling group (reenactment imagery is addressed directly in Sessions 7 and 8).



Client Name:
Deceased Name:
Facilitator(s) Name:

Intervention: Individual / RR Group
Type of Death: (Homicide/Suicide/Accidental/Combatant/Terrorist)

INSTRUMENT	Pre-Score & Date	Post-Score & Date
Beck Depression Inventory (BDI)		
Death Imagery Scale (DIS)		
Reenactment		
Rescue		
Revenge		
Reunion		
Remorse		
Complicated Grief Assessment (GCA)		
Impact of Events Scale-R (IES-R)		
Avoidance		
Intrusion		
Hyper-arousal		
Cumulative		
Pre-Screening:		
Post-Screening:		

VOCA Assessments Baseline: Also developed by Holly Prigerson, Ph.D., this instrument guides the clinician's consideration of how each individual's exposure to the death and the relationship to the deceased influence the likelihood of meeting diagnostic criteria for both traumatic grief and PTSD (obtained from the IES-R). Clinicians will also find the instrument useful for gathering demographic information on a systematic basis.

THE SCREENING PROCESS:

Initial: The clinician receiving the referral of an individual for RR should discuss the screening process during the initial contact, explaining its usefulness in planning appropriate treatment and in indicating change before and after treatment. The screening battery takes about 45 minutes to complete. The screening battery may be mailed to the individual prior to the interview, can be completed in the waiting room prior to the appointment or, the clinician may prefer to read the items with the individual and complete the battery during session. This is a practical as well as a clinical decision.

We suggest that clinicians use the battery interactively rather than "taking something from clients" which the client never sees again. The scores on each of the measures are shown and explained. In addition to its role in informing the clinician, clients often find this review and explanation to be an organizing as well as a caring experience.

Possible recommendations may include psychiatric consultation, individual therapy, RR, Crime Victims Compensation Program application support and referral to community resources (e.g., victim's assistance programs).

Follow-up: In addition to the pre-screening, the battery should be repeated upon completion of RR during the last session. We have found, as have many other clinicians/researchers, that mailing this type of information after individuals have completed treatment yields a very low rate of return.

Appendix B– Self-Assessment Screenings

Appendix B1

VOCA ASSESSMENTS: BASELINE

Client Name/ID#: _____ Date: _____

Part I: Background Characteristics

1. Age (years): _____
2. Sex: male female
3. Race: Caucasian African American Hispanic Other (specify) _____
4. Education: (circle highest level completed)
a. No formal schooling b. Elementary school c. Junior High d. High school
e. College f. Graduate school
5. Income: (monthly) _____
6. Where are you living now?
 - a. With parents
 - b. At school
 - c. With a friend
 - d. At an institution (Please describe.)
 - e. With a partner (including your or your partner's family.)
7. Have you been diagnosed with a psychiatric disorder in the past?

1 = yes 2 = no
8. If "yes" what diagnosis(es) have you been given?

9. Have you received treatment for a psychiatric disorder, or any other type of emotional problem in the past?

1 = yes 2 = no

10. If “yes” what treatments have you received? _____

11. Are you currently receiving treatment(s) for emotional problems aside from your participation in this program?

1 = yes 2 = no

12. If “yes” what treatments are you receiving at present? _____

Part II: Characteristics of the Loss and Exposure to it

1. What was your relationship to the person who died? (e.g., mother, father, sister, partner)

2. When did the loss occur? (date/how long ago) _____

3. How, or from what, did the person die? _____

4. Did you see the scene of the death? 1 = yes 2 = no

5. Did you see the person when s/he was injured? 1 = yes 2 = no

6. Did you try to help? 1 = yes 2 = no

7. Were you prevented from helping? 1 = yes 2 = no

8. Were you at the scene of injury/death before the victim was removed? 1 = yes 2 = no

9. Did you see the victim die? 1 = yes 2 = no

10. Were you the first person to discover the victim? 1 = yes 2 = no

11. Did you see the victim be taken to the hospital? 1 = yes 2 = no

12. Did the victim say anything? 1 = yes 2 = no

13. If “yes” what? _____

Part III: Relationship to the Deceased

1. How would you characterize your relationship to the deceased? Please check the place between the two poles that best characterizes your relationship to the deceased.

A.	Close										Distant
		1	2	3	4	5	6	7	8	9	10
B.	Peaceful										Conflictual
		1	2	3	4	5	6	7	8	9	10
C.	Easy										Difficult
		1	2	3	4	5	6	7	8	9	10
D.	Supportive										Unsupportive
		1	2	3	4	5	6	7	8	9	10
E.	Hostile										Compatible
		1	2	3	4	5	6	7	8	9	10
F.	Compatible										Incompatible
		1	2	3	4	5	6	7	8	9	10

2. How attached would you say you were to _____?

1 = extremely attached 2 = very attached 3 = somewhat attached
4 = a little attached 5 = not at all attached

3. How dependent would you say you were on _____?

1 = extremely dependent 2 = very dependent 3 = somewhat dependent
4 = a little dependent 5 = not at all dependent

Appendix B2 - Beck Depression Inventory Screening

BDI (A)

Name: _____ Date _____ Age _____ Sex _____

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0,1,2,3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several within a group seem to apply equally well, circle each one. *Be sure to read all the statements in each group before making your choice.*

- | | | | | | |
|----|---|--|-----|---|--|
| 1. | 0 | I do not feel sad. | 9. | 0 | I don't feel I am any worse than anybody else. |
| | 1 | I feel sad. | | 1 | I am critical of myself for my weaknesses. |
| | 2 | I am sad all the time and I can't snap out of it. | | 2 | I blame myself all the time for my faults. |
| | 3 | I am so sad or unhappy that I can't stand it. | | 3 | I blame myself for everything bad that happens. |
| 2. | 0 | I am not particularly discouraged about the future. | 10. | 0 | I don't have any thoughts of killing myself. |
| | 1 | I feel discouraged about the future. | | 1 | I have thought of killing myself, but I would not carry them out. |
| | 2 | I feel I have nothing to look forward to. | | 2 | I would like to kill myself. |
| | 3 | I feel that the future is hopeless and that things cannot improve. | | 3 | I would kill myself if I had the chance. |
| 3. | 0 | I do not feel like a failure | 11. | 0 | I don't cry any more than usual. |
| | 1 | I feel I have failed more than the average person. | | 1 | I cry more now than I used to. |
| | 2 | As I look back on my life, all I can see is a lot of failures. | | 2 | I cry all the time now. |
| | 3 | I feel I am a complete failure as a person. | | 3 | I used to be able to cry, but now I can't cry though I want to. |
| 4. | 0 | I get as much satisfaction out of things as I used to. | 12. | 0 | I am no more irritated now than I ever am. |
| | 1 | I don't enjoy things the way I used to. | | 1 | I get annoyed or irritated more easily than I used to. |
| | 2 | I don't get real satisfaction out of anything anymore. | | 2 | I feel irritated all the time now. |
| | 3 | I am dissatisfied or bored with everything. | | 3 | I don't get irritated at all by the things that used to irritate me. |
| 5. | 0 | I don't feel particularly guilty. | 13. | 0 | I have not lost interest in other people. |
| | 1 | I feel guilty a good part of the time. | | 1 | I am less interested in other people than I used to be. |
| | 2 | I feel quite guilty most of the time. | | 2 | I have lost most of my interest in other people. |
| | 3 | I feel guilty all of the time. | | 3 | I have lost all of my interest in other people. |
| 6. | 0 | I don't feel I am being punished. | 14. | 0 | I make decisions about as well as I ever could. |
| | 1 | I feel I may be punished. | | 1 | I put off making decisions more than I used to. |
| | 2 | I expect to be punished. | | 2 | I have greater difficulty making decisions than ever. |
| | 3 | I feel I am being punished. | | 3 | I can't make decisions at all anymore. |
| 7. | 0 | I don't feel disappointed in myself. | 15. | 0 | I don't feel I look any worse than I used to. |
| | 1 | I am disappointed in myself. | | 1 | I am worried that I am looking old or unattractive. |
| | 2 | I am disgusted with myself. | | 2 | I feel that there are permanent changes in my appearance that make me look unattractive. |
| | 3 | I hate myself. | | 3 | I believe that I look ugly. |
| 8. | 0 | I can work about as well as before. | 16. | 0 | I don't get more tired than usual. |
| | 1 | It takes extra effort to get started at doing something. | | 1 | I get tired more easily than I used to. |
| | 2 | I have to push myself very hard to do anything. | | 2 | I get tired from doing almost anything. |
| | 3 | I can't do any work at all. | | 3 | I am too tired to do anything. |

- | | | | | | |
|-----|------------------|---|-----|------------------|--|
| 17. | 0
1
2
3 | I can sleep as well as usual.
I don't sleep as well as I used to.
I wake up 1-2 hours earlier than I used to.
I wake up several hours earlier than I used to and cannot get back to sleep. | 20. | 0
1
2
3 | I haven't lost much weight, if any, lately.
I have lost more than 5 pounds.
I have lost more than 10 pounds.
I have lost more than 15 pounds. |
| 18. | 0
1
2
3 | I don't feel I am any worse than anybody else.
I am critical of myself for my weaknesses or mistakes.
I blame myself all the time for my faults.
I blame myself for everything bad that happens. | 21. | 0
1
2
3 | I am no more worried about my health than usual.
I am worried about physical problems such as aches, pains; or upset stomach; or constipation.
I am very worried about physical problems and it's hard to think of much else.
I am so worried about my physical problems that I cannot think about anything else. |
| 19. | 0
1
2
3 | My appetite is no worse than usual.
My appetite is not as good as it used to be.
My appetite is much worse now.
I have not appetite at all any more. | 22. | 0
1
2
3 | I have not noticed any recent change in my interest in sex.
I am less interested in sex than I used to be.
I am much less interested in sex now.
I have lost interest in sex completely. |

_____ Subtotal Page 1

_____ Subtotal Page 2

_____ Total Score

Appendix B3

Complicated Grief Assessment – Self-Report

Holly Prigerson, Ph.D., Paul K. Maciejewski, Ph.D.

Please mark the box next to the answer that best describes how you have been feeling over the past month. The blanks refer to the person you have lost.

1.a. How often do you feel yourself longing and yearning for _____?

- Almost never (less than once a month) 1
- Rarely (once a month or more, less than once a week) 2
- Sometimes (once a week or more, less than once a day) 3
- Often (once a day) 4
- Always (several times every day) 5

1.b. Is the yearning distressing to you or disruptive to your daily routine?

Yes _____
No _____

2. To what extent have you had difficulty accepting the death?

- No difficulty accepting the death 1
- A slight sense of difficulty accepting the death 2
- Some difficulty accepting the death 3
- A marked sense of difficulty accepting the death 4
- Overwhelming difficulty accepting the death 5

3. To what extent have you had difficulty trusting people since _____ died?

- No difficulty trusting others 1
- A slight sense of difficulty trusting others 2
- Some sense of difficulty trusting others 3
- A marked sense of difficulty trusting others 4
- An overwhelming sense of difficulty trusting others 5

4. To what extent have you felt bitter over _____ 's death?

- No sense of bitterness 1
- A slight sense of bitterness 2
- Some sense of bitterness 3
- A marked sense of bitterness 4
- An overwhelming sense of bitterness 5

5. Sometimes people who lose a loved one feel uneasy about moving on with their life. To what extent do you feel that moving on (for example, making new friends, pursuing new interests) would be difficult for you?

- Moving on would not be difficult 1
- Moving on would be a little difficult 2
- Moving on would be somewhat difficult 3
- Moving on would be very difficult 4
- Moving on would be extremely difficult 5

6. To what extent have you felt emotionally numb (e.g., detached from others) since _____'s death?

- No sense of numbness 1
- A slight sense of numbness 2
- Some sense of numbness 3
- A marked sense of numbness 4
- An overwhelming sense of numbness 5

7. To what extent do you feel that life is empty or meaningless without _____?

- No sense of emptiness or meaninglessness 1
- A slight sense of emptiness or meaninglessness 2
- Some sense of emptiness 3
- A marked sense of emptiness 4
- An overwhelming sense of emptiness 5

8. To what extent to you feel that the future holds no meaning or purpose without _____?

- No sense that the future holds no purpose 1
- A slight sense that the future holds no purpose 2
- Some sense that the future holds no purpose 3
- A marked sense that the future holds no purpose 4
- An overwhelming sense that the future holds no purpose 5

9. To what extent have you felt on edge, jumpy, or easily startled since the death of _____?

- No feelings of being on edge 1
- A slight sense of feeling on edge 2
- Some sense of feeling on edge 3
- A marked sense of feeling on edge 4
- An overwhelming sense of feeling on edge 5

10. Have the above feelings caused you trouble in your family, social, work, or leisure life?

Yes _____
No _____

11. Have the above feelings lasted for at least six months?

Yes _____
No _____

Complicated Grief Assessment

Please mark the box next to the answer that best describes how the respondent has been feeling over the past month. The blanks refer to the deceased person over whom the respondent is grieving.

Criterion A:

A.1a. In the past month, how often have you felt yourself longing and yearning for _____?

- Almost never (less than once a month) - 1
- Rarely (2-6 times/month) - 2
- Sometimes (more than 7 times/month, but not every day) - 3
- Every day - 4
- Several times every day - 5

A.1b. In the past month has the yearning been distressing to you or disruptive to your daily routine?

- Yes
- No

A frequency of “every day” or “several times a day” OR distress or disruption caused by the yearning is required for a Complicated Grief diagnosis.

Criteria B:

Below, 4 of 8 B Criteria must have an intensity of “4” or “5”.

B1. In the past month, to what extent have you had difficulty accepting the death?

- No difficulty accepting the death - 1
- A slight sense of difficulty accepting the death - 2
- Some difficulty accepting the death - 3
- A marked sense of difficulty accepting the death - 4
- Overwhelming difficulty accepting the death - 5

B2. In the past month, to what extent have you had difficulty trusting people?

- No difficulty trusting others - 1
- A slight sense of difficulty trusting others - 2
- Some sense of difficulty trusting others - 3
- A marked sense of difficulty trusting others - 4
- An overwhelming sense of difficulty trusting others - 5

B.3. In the past month, to what extent have you felt bitter over _____'s death?

- No sense of bitterness - 1
- A slight sense of bitterness - 2
- Some sense of bitterness - 3
- A marked sense of bitterness - 4
- An overwhelming sense of bitterness - 5

B.4. Sometimes people who lose a loved one feel uneasy about moving on with their life. In the past month, to what extent do you feel that moving on (for example, making new friends, pursuing new interests) would be difficult for you?

- Moving on would not be difficult - 1
- Moving on would be a little difficult - 2
- Moving on would be somewhat difficult - 3
- Moving on would be very difficult - 4
- Moving on would be extremely difficult - 5

B.5. In the past month to what extent have you felt emotionally numb or had difficulty connecting with others?

- No sense of numbness - 1
- A slight sense of numbness - 2
- Some sense of numbness - 3
- A marked sense of numbness - 4
- An overwhelming sense of numbness - 5

B.6. In the past month to what extent do you feel that life is empty or meaningless without _____?

- No sense of emptiness or meaninglessness - 1
- A slight sense of emptiness or meaninglessness - 2
- Some sense of emptiness - 3
- A marked sense of emptiness - 4
- An overwhelming sense of emptiness - 5

B.7. In the past month to what extent do you feel that the future holds no meaning or purpose without _____?

- No sense that the future holds no purpose - 1
- A slight sense that the future holds no purpose - 2
- Some sense that the future holds no purpose - 3
- A marked sense that the future holds no purpose - 4
- An overwhelming sense that the future holds no purpose - 5

B.8. In the past month to what extent have you felt on edge, jumpy, or easily startled?

- No feelings of being on edge - 1
- A slight sense of feeling on edge - 2
- Some sense of feeling on edge - 3
- A marked sense of feeling on edge - 4
- An overwhelming sense of feeling on edge - 5

Criterion C. Has your grief resulted in impairment in your social, occupational, or other areas of functioning? For instance, does your grief make it difficult for you to perform your normal daily activities?

- Yes - 1
- No - 2
- REF - 97
- DK - 98

If Yes, then Criterion C is met.

Criterion D. Have any of the above symptoms lasted for at least six months?

- Yes - 1
- No - 2

The symptoms must have persisted for at least six months to be considered “Yes”. If the respondent suggests that the symptoms have occurred intermittently, then mark “No”.

If Yes, then Criterion D is met.

Complicated Grief Diagnosis = Criteria A, B, C, and D are met.

- Yes - 1
- No - 2

Name: _____

Date: _____

Instructions: **Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you. DURING THE PAST SEVEN DAYS with respect to _____, which occurred on _____. How much were you distressed or bothered by these difficulties?**

FREQUENCY

	<u>Not at All</u>	<u>A Little Bit</u>	<u>Moderately</u>	<u>Quite a Bit</u>	<u>Extremely</u>
1. Any reminder brought back feelings about it.	0	1	2	3	4
2. I had trouble staying asleep.	0	1	2	3	4
3. Other things kept making me think about it.	0	1	2	3	4
4. I felt irritable and angry.	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it.	0	1	2	3	4
6. I thought about it when I didn't mean to.	0	1	2	3	4
7. I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8. I stayed away from reminders of it.	0	1	2	3	4
9. Pictures of it popped into my mind.	0	1	2	3	4
10. I was jumpy and easily startled.	0	1	2	3	4
11. I tried not to think about it.	0	1	2	3	4
12. I was aware that I still had feelings about it, but didn't deal with them.	0	1	2	3	4
13. My feelings about it were kind of numb.	0	1	2	3	4
14. I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15. I had trouble falling asleep.	0	1	2	3	4
16. I had waves of strong feelings about it.	0	1	2	3	4
17. I tried to remove it from memory.	0	1	2	3	4
18. I had trouble concentrating.	0	1	2	3	4
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20. I had dreams about it.	0	1	2	3	4
21. I felt watchful and on-guard.	0	1	2	3	4
22. I tried not to talk about it.	0	1	2	3	4

Appendix B5

DEATH IMAGERY SCALE-Revised

Name: _____

Client Age: _____

Cause of Death

Time Since Death: _____ (months)

Natural

Unnatural

Below is a list of images reported after the death of a friend or relative (as thoughts or visual “flashbacks”, [i.e., wide awake] or dreams while asleep.) Please underline the type of types of imagery experienced and check their frequency within the last month.

FREQUENCY

	None	Once/month	Once/week	Daily
1. Reenactment: I experienced a fantasied replay of the dying (as thought, visual “flashback”, dream).				
2. Rescue: I experience a fantasy of rescuing the person from dying (as thought, visual “flashback”, dream).				
3. Revenge: I experience a fantasy of retaliation for this dying (as thought, visual “flashback”, dream).				
4. Reunion: I experience a fantasy of reunion with the deceased family member and/or friend (as thought, visual “flashback”, dream).				
5. Remorse: I experience a fantasy that I should have somehow prevented the dying from happening (as thought, visual “flashback”, dream).				

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Virginia Mason Medical Center 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.

Fanny Correa, MSW, CT
Clinical Director
Separation and Loss Services

Appendix C2 – Group Agenda/Restorative Retelling Group Sessions

Facilitators:

<u>Session</u>	<u>Date</u>	<u>Topic</u>
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: Commemorative session. Using journal, pictures, poetry, music, food or other special things, tell us about your loved one.
6		Report on last week Focus: Commemorative 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

**Separation and Loss
Group Progress Notes**

Client Name: _____ Facilitator(s)' Names: _____
Group Name: Restorative Retelling Begin Date: _____

Group One:

Group Two:

Group Three:

Group Four:

Group Five:

Group Six:

Group Seven:

Group Eight:

Group Nine:

Group Ten:

Appendix C3 – 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**
- **Commemorative session**
- **Death imagery**
- **Family and friends**
- **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 C5 – 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 C6

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. Physically

- 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. Spiritually

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

3. Emotionality

- 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

5. 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?

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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.

Group Work with Adolescent Survivors of Homicide Victims (children and adolescents)

Children's Bureau of Greater New Orleans – Project LAST, 2001

Salloum, A.

Accommodation to Violent Dying (adults)

Separation and Loss Services, Virginia Mason Medical Center, revised July 2006

Rynearson, E.K., Correa, F.

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.