

# Family Systems Therapy

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The individual, group, and couple psychotherapy approaches presented in other chapters in this book may be of direct benefit not only to patients with complex traumatic stress disorders but also indirectly to their entire families. However, the psychosocial challenges to the family having a member with complex traumatic stress disorder impairments may alter the family system in profound ways that are not readily addressed without direct family involvement in psychotherapy. If families are helped to restore the functionality of all their relationships, including but not limited to the relationships with the traumatized member, then they may more effectively contribute to (and not inadvertently undermine) that troubled member's recovery and healthy adaptation. Moreover, although complex traumatic stress disorders are not "contagious," it is not uncommon for multiple family members to have been directly or indirectly affected by psychological trauma and, by definition, this has occurred when the trauma is intrafamilial (e.g., incest, domestic violence).

Therefore, this chapter provides an overview of family systems therapy approaches to complex traumatic stress disorders, including clinical illustrations of two empirically based models of family therapy designed or adapted to address complex traumatic stress sequelae. Case vignettes from each family therapy approach demonstrate how family systems interventions can assist children and adults in families with complex traumatic stress disorders.

## **RATIONALE FOR FAMILY THERAPY WITH POSTTRAUMATIC STRESS AND COMPLEX TRAUMATIC STRESS DISORDERS**

Family members are deeply affected and family relationships tend to be profoundly altered when any family member experiences psychological trauma

and develops posttraumatic stress disorder (PTSD; Schumm, Vranceanu, & Hobfoll, 2004; Smith & Fisher, 2008). It is stressful at best, and overwhelming and demoralizing at worst, to live with a family member who is troubled by and attempting to avoid feeling distress associated with memories or reminders of traumatic experiences. The impact of PTSD on the entire family, including earlier (e.g., parents, grandparents) and current (e.g., spouse/partners, siblings, children) generations, is profound and potentially debilitating. It is rare that a family member's PTSD (or resultant behavior) causes other family members to be "traumatized" themselves: Abuse or family violence is not caused by PTSD. However, the strain on family members who attempt to care for and cope with another member who, due to PTSD, interacts with intense and unpredictable hyperarousal or emotional numbing, detachment, and avoidance, can be substantial. The burden of caring for and witnessing the traumatic memories and reactions of a family member may cause adults or children in the family to feel significant distress and a sense of helplessness (i.e., vicarious traumatization; Pearlman & Caringi, Chapter 10, this volume).

The adverse effects of psychological trauma and traumatic stress disorders on the family are particularly profound when they result from abuse, abandonment by caregiver(s), severe neglect, domestic violence, or death or gruesome injury due to community violence, war, or terrorism. People in the same family often have different levels of actual or perceived exposure to traumatic events, and different types and degrees of traumatic stress problems (Saltzman, Babayon, Lester, Beardslee, & Pynoos, 2008). Family members' reactions to traumatic events also are influenced by risk and protective factors, including history of psychological trauma or loss; early life relationship with caregivers; psychological and behavioral problems, temperament, and intellectual functioning; and personality, social support, and community and family resources (Pat-Horenczyk, Rabinowitz, Rice, & Tucker-Levin, 2008). As a result, the family members to whom a traumatized person looks for help and protection when exposed to psychological trauma are likely to have different needs and courses of recovery, whether they were directly or indirectly affected by a psychological trauma (Layne et al., 2008). When these differences lead to dysynchrony in the nature and timing of posttraumatic reactions and recovery among family members, heightened levels of stress, discord, and alienation may occur within the family (Saltzman et al., in press) at a time when family cohesion is most needed by all affected family members (Hawkins & Manne, 2004).

If psychological trauma occurs as a result of the actions of a parent or caregiver(s), all family relationships may be altered, not just those with the offending or neglectful caregiver(s), as a result of the profound issues of trust, protection, and responsibility raised by intentional intrafamilial trauma (Courtois, 1988). Nonoffending caregiver(s) and other family members (e.g., siblings) may experience abuse or violence as psychologically traumatic because they are witnesses or collateral victims, or due to a sense of shock and vulnerability, or guilt, shame, and bereavement, as a result of having failed to prevent

the traumatic events. Abuse perpetrated by persons outside the immediate family may lead children to feel isolated from or rejected by their family as a result of social stigma and a sense of helplessness (at times compounded by family members' reactions of denial or nonsupport), and caregivers and other family members may experience a sense of guilt, shame, and victimization (particularly if the perpetrator was a trusted individual, or if family members believe they should have known and prevented the abuse). If the psychological trauma involves family, family members (including children) often feel guilty for failing to prevent harm to caregiver(s) or other family members. All of these sequelae may be mediated by ethnic/cultural and other meanings systems (see Brown, Chapter 8, this volume).

Spousal relationships also are substantially impacted when either or both partners, or a child suffers traumatic stress problems. This in turn can reduce spouses' abilities to effectively support their children when traumatic stressors occur. Spousal relationships and parenting are crucial sources of support and recovery for every family member in the wake of exposure to psychological trauma. Conversely, when parents respond to the stress of a traumatic experience with hostility, anger, anxiety, and conflict, the family environment can exacerbate trauma-related symptoms for family members and for the family system. When a family encounters particularly severe stress (e.g., in a conflictual divorce or due to domestic violence), the risk for parenting practices to be negatively influenced by irritability, insensitivity, and harshness also is high. Additional factors (e.g., parental history of psychological trauma, or mental health or addiction problems) can exacerbate the disruption of parenting practices. Parental experience of traumatic stress symptoms tends to interfere with parents' ability to maintain family routines and roles (Jordan et al., 1992; Ruscio, Weathers, King, & King, 2002). Children depend on their parents to provide emotional support, role modeling, and physical safety and/or security precisely by keeping family routines and roles intact. Thus, when parents experience traumatic stress symptoms, their children may have difficulty managing their own reactions to the traumatic stressors. This appears to be true not only for children directly victimized by a traumatic event but also for those who simply have been told about a family member's violent or traumatic experience (Saltzman et al., 2008). Parental withdrawal, over-protectiveness, or preoccupation with trauma are relational factors that may indirectly exacerbate a child's traumatic stress symptoms (Scheeringa et al., 2007). Meiser-Stedman, Yule, Dalgleish, Smith, and Glucksman (2006) found parental depression to be positively correlated with posttraumatic stress symptoms in their children.

A child's traumatic stress experiences or reactions also may be traumatic for the parents. Parents may develop posttraumatic stress symptoms based on their child's experiencing potentially traumatic stressors, regardless of whether the parents have been directly exposed to the traumatic event itself (Cohen, in press). Psychological trauma affects the entire family system, potentially across many generations (Horenczyk et al., 2008). Children of traumatized parent(s)

are at greater risk of developing PTSD or related psychological difficulties than other children if they are exposed to psychological trauma themselves (Brand, Engel, Canfield, & Yehuda, 2006). Evidence indicates that a risk factor for PTSD—reduced resting cortisol levels—may be transmitted genetically from mothers with terrorism-related PTSD to their 9-month-old babies (Brand et al., 2006).

On the positive side, family relationships also are indispensable to the traumatized person's recovery, because they simultaneously provide essential support for the restoration of emotional security, physical safety, and hope, and for the resumption of healthy growth and development in the wake of psychological trauma. Children, adolescents, and even adults often look to parents, siblings, and other adult relatives as a source of support during a variety of potentially traumatic situations, including life-threatening illness, unexpected loss of a loved one or close friend, violence in the family or community, and disasters and traumatic accidents. In these circumstances, children in families characterized by chaos, disorganization, anger, emotional detachment, anxiety, or depression are at increased risk of PTSD, whereas children in families that are cohesive, caring, and emotionally involved are more likely to recover (Saltzman et al., 2008).

### **EVIDENCE BASE FOR FAMILY THERAPY WITH PTSD AND COMPLEX TRAUMATIC STRESS DISORDERS**

Meta-analytic studies have found family based treatments to be more effective than treatment as usual (TAU) and at least as successful as individual psychotherapies for a variety of psychological disorders (Diamond & Josephson, 2005). Couple therapy interventions based on behavioral (Rotunda, O'Farrell, Murphy, & Babey, 2008) or cognitive-behavioral (Monson, Schnurr, Stevens, & Guthrie, 2004) approaches to altering conflicted, avoidant, addictive (e.g., substance abuse) or nonsupportive interaction patterns have shown promise in pilot studies (i.e., no control group or comparison therapy) with military veterans with PTSD and their partners.

However, conjoint family therapy for the treatment of adults with PTSD (Lebow & Rekart, 2004; Walsh & Rothbaum, 2007) or disorders involving complex traumatic stress impairment (e.g., pathological psychoform or somatoform dissociation, affect dysregulation, or profound interpersonal and spiritual alienation) has not been studied scientifically. One randomized clinical trial (RCT) compared a low intensity (i.e., four to eight sessions over a 9- to 18-month period), family-based grief therapy to routine care with families of terminally ill adult patients. This family therapy had limited benefit and primarily only with "sullen" or "hostile" families (Kissane et al., 2006).

The strongest evidence for the efficacy of family therapy for traumatic stress disorders is provided by studies with families of traumatized toddlers and preschool- or early elementary school-age children of relational/psycho-

dynamic (child–parent psychotherapy [CPP]; Van Horn & Lieberman, 2008) and cognitive-behavioral parent management therapy (parent–child interaction therapy [PCIT]; Eyberg & McDiarmid, 2005). Neither CPP nor PCIT was originally developed for traumatized children, but both have been used clinically with families of children who have been maltreated or exposed to traumatic violence. CPP guides the caregiver of a traumatized toddler or young child toward developmentally appropriate, responsive, and nurturing attitudes and behavior, while interacting with the child (Van Horn & Lieberman, 2008). In RCTs, CPP has been shown to be superior to case management plus TAU in achieving sustained reductions in PTSD symptoms and behavior problems in preschool children who witnessed domestic violence (Lieberman, Ghosh Ippen, & Van Horn, 2006; Lieberman, Van Horn, & Ghosh Ippen, 2005) and in enhancing the likelihood of secure attachment in the parent–child dyad and in maltreated toddlers and preschoolers beliefs about parents (Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002). Other relationally focused family therapy models for incestuous (Giarretto, 1982; Maddock & Larson, 1995; Sheinberg & Fraenkel, 2001; Trepper & Barrett, 1989) or dissociative (Benjamin & Benjamin, 1992) families have shown promise clinically but not been validated in systematic research studies.

PCIT is a highly structured educational intervention in which parents are coached by the therapist, while they play with their child, to consistently reinforce prosocial behavior and to ignore aggressive, impulsive, or noncompliant behavior. One RCT showed that a modification of PCIT for low-income, physically abusive parents and their children was more effective than a parenting group in reducing harsh, punitive, and nonresponsive parent behaviors and preventing additional charges of abuse during the following 2–3 years. Evidence that PCIT may also reduce maltreated children’s behavior problems and parenting stress was found in a quasi-experimental study (Timmer, Urquiza, Zebell, & McGrath, 2005), although maltreated children showed less favorable change than nonmaltreated children, and the parents frequently (64%) dropped out of therapy when behavior problems were severe. PCIT uniquely focuses on assisting abusive parents to reestablish healthy relationships with their children, whereas other approaches, such as CPP, are used primarily with nonoffending parents.

Brief family-based cognitive-behavioral therapies (CBTs) for families of adolescent survivors of cancer (Kazak et al., 2004) and young children newly diagnosed with cancer (Kazak et al., 2005) have been shown to be superior to routine palliative care in reducing some PTSD symptoms for adolescents and their fathers (but not their mothers), and anxiety and PTSD symptoms for both mothers and fathers of newly diagnosed pediatric cancer patients. The intervention called the Surviving Cancer Competently Intervention Program (SCCIP), involved a single day, with four sessions (both single-family and multifamily groups) for the adolescent survivors and their families, and three sessions in a single-family format for the families of newly diagnosed children with cancer.

CBTs for child and adolescent PTSD usually include a component involving parents or other adult caregivers (Stallard, 2006). For example, Kolko (1996) compared individual and family-based CBT to community-based services in work with physically abused children (ages 6–13 years). Individual CBT involved separate sessions for both parent and child, whereas family-based CBT included members of the entire family together. Community-based services involved education about parenting and homemaking skills provided in the home. Individual and family-based CBT resulted in more substantial reductions in PTSD, emotional and behavioral problems, and parent-to-child violence following therapy and at a 1-year follow-up assessment than did community services. The specific value of parental involvement was more clearly demonstrated by Deblinger, Lippmann, and Steer (1996), who found that involvement by the nonoffending mother in trauma-focused CBT was associated with greater reductions in PTSD symptoms among sexually abused children than when the parent was not directly included in the therapy. At 6- and 12-month follow-up assessments, not only the sexually abused children but also their adult caregivers reported substantially improved PTSD and depression symptoms following trauma-focused CBT, but not when only the child was treated with a supportive psychotherapy (Deblinger, Mannarino, Cohen, & Steer, 2006).

With the exception of CPP for traumatized young children and their caregivers, none of these approaches to family therapy was developed or adapted for complex traumatic stress disorders. The only outcome measure in CPP clinical trials that falls within the domain of complex traumatic stress disorders is toddlers' secure versus disorganized attachment. Perhaps the closest approximation to family therapy for complex traumatic stress disorders is an approach to marital and family therapy developed for borderline personality disorder (BPD) (Kreisman & Kreisman, 2004). The SET (support, empathy, truth) model of marital and family therapy for BPD is psychodynamically based. The therapist addresses the impact of emotion dysregulation, suicidal and other crises, and "acting-out" behavior on the spouse/partner and other family members, while assisting them and the identified patient in developing empathic understanding of each other and more honest supportive communication. However, neither the SET model nor any other family or couple therapy for BPD has been scientifically evaluated.

Although all of these family- or couple-based psychotherapies seek to improve the trust and communication between family members, only CPP, SCCIP, and the relational therapies for incestuous families explicitly use a family systems approach to treatment. CCP helps the caregiver and child experiment with new roles (e.g., the caregiver as facilitator and guide rather than disciplinarian or detached outsider) and perspectives on each other's thoughts and emotions (e.g., helping the caregiver to empathize with the child's developmentally appropriate fears and aspirations). SCCIP purposively "joins" with family members by aligning with their primary goals, and working toward developing ways that family members can mutually support one another.

## **FAMILY SYSTEMS MODELS: DESCRIPTION AND APPLICATION TO COMPLEX TRAUMATIC STRESS DISORDERS**

Family systems approaches to psychotherapy aim not just to change individual family members but to restructure, rebuild, or restore healthy family relationships. Family therapy for PTSD has been described as aiming either to repair the family system or to enhance the available social support utilized by the family (Riggs, 2000). Family systems models attempt to facilitate the following features of family relationships related to cohesive, respectful, trustworthy, responsible, and caring communication and emotional connections: (1) the development of role expectations and behavioral “rules” that are explicit; (2) open and sensitive discussion of troubling past experiences (“myths” and “secrets”); (3) a balance of individuality and togetherness (“relational boundaries”); (4) strong but inclusive leadership by parents (“family hierarchy”); (5) respectful and affectionate approaches to communication; and (6) effective family problem solving.

### **Family Roles**

A family member who is affectively dysregulated, dissociated, debilitated by persistent unexplained or treatment-refractory physical problems, emotionally detached or explosive, and psychologically and spiritually demoralized may take on roles in the family, such as a perpetually dependent “identified patient,” the family “scapegoat,” an unpredictably destructive “toxic” perpetrator, or an “invisible” outsider. Other family members often take on complementary roles, such as the “rescuer,” who unsuccessfully attempts to “save” or “cure” the traumatized family member; the “enabler,” who acquiesces to the troubled family member’s anger, coercive demands, or impulsive behaviors; the “protector,” who attempts to keep both the traumatized member and other family members from being harmed emotionally or otherwise by the traumatized member’s behavior; or the “rock of strength,” who tries to take care of everyone else’s needs in the family. Such family roles are not explicitly defined or assigned, but generally are well known to all members and assumed to be immutable, because they rarely change and seem to be necessary to cope with family members’ traumatic stress impairments.

### **Rules**

As a counterpart to implicit family roles, that family members develop unspoken expectations as a result of coping with persistent stress, turmoil, and disappointment associated with complex traumatic stress disorders. These implicit and pervasive expectations become fixed in the form of “rules” that make interactions predictable, albeit dissatisfying and demoralizing. Trauma-based “rules” might include “Don’t have feelings,” “Don’t treat abuse as real,”

“Don’t tell,” “Whatever you do, don’t upset [traumatized family member] or else he’ll lose it and there will be hell to pay for all of us,” “Other family members have to put their needs aside and do whatever [traumatized family member] needs or demands because she was abused,” “He [traumatized family member] can’t control the urges to [use substances, get in fights, do risky impulsive behaviors] because he has PTSD” or “She should just stop overreacting to everything, and grow up, and not be such a burden for all of us,” and “We can’t go out anywhere because he gets so upset that it ruins it for everyone” (see Courtois, 1988).

### **Family Myths and Secrets**

Family roles and rules tend to be based upon beliefs that have taken on the status of both *myth* (i.e., a putatively incontrovertible truth about the family or the traumatized member that has become an integral part of the “story” of the family or the person’s history) and *secret* (i.e., something that one or several family members hide from other family members, often due to a sense of guilt, shame, or remorse, or due to fear or distrust concerning the reactions that would result should the secret be known). Complex trauma often leads to secrets (e.g., the very fact of abuse, or the identity of a perpetrator, may be hidden) and may also lead to a sense of betrayal, abandonment, or violation of trust that can result in family members’ harboring other secrets (e.g., an extramarital affair in reaction to infidelity or violence by the spouse; “alliances” between a nonabusing parent and her children not to tell an abusive parent things that might lead to angry reprisals or further abuse). Secrecy may become a way of life for survivors of childhood developmental trauma, such that they keep innocuous, as well as very important, facts about themselves or others, or thoughts and feelings, hidden in their adult life.

### **Family Hierarchy and Relational Boundaries**

Troubled families often are disorganized in terms of their intergenerational hierarchy (i.e., older generation(s) serving as role model(s) and leader(s) for subsequent generations) and boundaries in relationships (i.e., maintaining a balance between closeness in the emotional connections between family members, without extreme overinvolvement [enmeshment], and autonomy and self-determination for each individual, without emotional detachment by or rejection of any member). The distress associated with complex traumatic stress disorders may lead parents to act more like children and children to take on a pseudo-adult demeanor and sense of responsibility (the “parentified” child and role reversal). Sexual or physical abuse that occurs within the family involves a fundamental breakdown of family hierarchy and relational boundaries: Parent(s) are harming or failing to protect their children; children are forced to be too intimate with, and to distance and protect themselves against, the very people with whom they should be safest and emotionally close but not enmeshed.



## Family Communication and Problem-Solving Styles

Families differ in the openness and flexibility (vs. rigidity), mutuality (vs. coercion and authoritarianism), and emotional responsivity (vs. detachment or rejection) of their styles of communicating and solving problems. Living with a complex traumatic stress disorder, whether one's own or that of a family member, tends to lead communication and problem solving to become rigid, coercive and controlling, and emotionally detached or rejecting, because these styles are adaptive in life and death emergencies, and developmental traumas can lead a child to adopt (or an adult to fall back upon) a mentality and coping style dominated by desperate attempts to survive, no matter what the cost.

## EVIDENCE-INFORMED FAMILY THERAPY MODELS FOR COMPLEX TRAUMATIC STRESS DISORDERS

With the exception of CPP, no family therapy modality has been validated scientifically for the treatment of PTSD or complex traumatic stress disorders. Therefore, with very young traumatized children (i.e., infants, toddlers, preschoolers), CPP is the treatment of choice to reduce traumatic stress symptoms, and to enhance the parent-child relationship and the security of the child's attachment working models. There also is recent evidence to suggest that trauma-focused cognitive-behavioral therapy (TF-CBT) (Cohen, Mannarino, & Deblinger, 2006) may be feasible and beneficial with traumatized young children (Scheeringa et al., 2007).

PCIT has shown promise with abusive parents and their children, as has SCCIP with families in which a child has cancer. Both interventions emphasize structured behavioral skills to enhance parents' ability to be responsive to their child's emotions and to assist their child with behavioral problems (typically, anger, impulsivity, and oppositionality in PCIT, and a mix of less severe externalizing and internalizing [e.g., anxiety, isolation, regression] problems in SCCIP). SCCIP includes brief family engagement interventions, but PCIT does not. These family-based therapies may be useful on a selective basis with complex traumatic stress disorders.

A family-based therapeutic intervention integrating cognitive-behavioral therapy (CBT) and family systems therapy (FST) has been developed for adolescents with PTSD or complex traumatic stress disorders (Faust & Katchen, 2004), although this model has not been described in sufficient detail to be replicable or scientifically validated. Structural (Minuchin, 1974) and strategic (Madanes, 1990) variations of FST are utilized to help the entire family to identify and change problematic roles, rules, relational boundaries, and communication patterns. CBT with the traumatized child includes parental psychoeducation and *in vivo* fear reduction exercises. While described as applicable with "complicated posttraumatic stress reactions" (Faust & Katchen, 2004), CBT-FST appears to focus primarily on addressing PTSD symptoms.

Two recently developed models were designed to enhance family self-regulation as a treatment for complex traumatic stress disorders. Both models aim to shift family members' perspectives from blaming or excusing traumatized family members (the so-called "identified patient") to working together to improve every member's self-regulation and the family system's ability to react to internal and external stressors in a regulated rather than reactive manner.

### **FAMILY SYSTEMS TRAUMA AFFECT REGULATION: GUIDELINES FOR EDUCATION AND THERAPY (FS/TARGET)**

A family systems adaptation of the self-regulation-based TARGET intervention for complex traumatic stress disorders (Ford & Russo, 2006) provides the entire family with psychoeducation about the biology of traumatic stress (and addiction, when applicable). FS/TARGET also teaches all family members a skills set for anticipating and managing stress reactions in ways that support both self-regulation by each member and the family's overall ability to develop roles, rules, boundaries, and communication and decision-making patterns that promote self-regulation.

FS/TARGET therapists address several key teaching points and therapeutic goals/challenges in every session to organize family systems intervention in a systematic manner paralleling the sequence of self-regulation components (the "FREEDOM steps") taught by TARGET.

1. *Focusing*: In addition to beginning, ending, and periodically interjecting into each session a brief exercise designed to enhance purposeful self-reflective attention (the "SOS" for "focusing"), the FS/TARGET therapist's first guiding question is: How does each family member achieve and sustain focused attention, and what are the specific verbal and nonverbal behavioral signs for each family member that distinguish between states of focused self-regulation and stress reactivity? To provide a strength-based model encouraging family members to view themselves and each other as capable of self-regulation and to support one another in doing so, FS/TARGET therapists observe and highlight for the family examples of each member being well-regulated.

2. *Recognizing stress triggers*: FS/TARGET integrates the identification of specific cues that serve as "triggers" for family members' stress reactions (including all family members, not just the traumatized children). The multidimensional family therapy tenet of facilitating nonblaming and direct communication between all family members "in the moment" in each therapy session (Liddle, Rodriguez, Dakof, Kanzki, & Marvel, 2005) provides family members with a model and specific nonjudgmental language for being aware of, talking openly about, and being more sensitive to the precise cues that elicit stress reactions. Whereas a parent might describe "everything she does" as a "stress

trigger” when feeling angry, hurt, helpless, and confused by the behavior of an adolescent daughter, the therapist guides the parent toward recognizing specific nonverbal (e.g., a certain “look” or tone of voice) or verbal (e.g., certain words that connote a lack of respect or compliance) triggers. When each person’s specific stress “triggers” are understood by all, family members can be helped to anticipate and prevent or manage trigger interactions, thereby shifting their view of each other from globally stress-inducing to understandably stress reactive.

3. *Identifying main Emotion states (and distinguishing these from reactive emotion states):* To address the alternating extremes of emotional under- and overexpression that often characterize families with traumatized children, FS/TARGET engages all family members in a dialogue and learning process designed to enable them to distinguish between emotion states that are primarily a reflection of stress reactivity and those that are more grounded and grounding. Dysregulated emotion states involving either hyperarousal (e.g., rage, terror, disgust, contempt) or hypoarousal (e.g., guilt, despair, shame, dissociative emotional emptiness) are identified in family interactions, redefined as useful signals that triggers are occurring, and relabeled as specific emotions (instead of as global distress, hopelessness, helplessness, or annoyance). Family members are assisted in defining and recognizing nonreactive emotion states (i.e., not driven by a sense of unspoken threat), that instead are expressions of a sense of security, accomplishment, or positive anticipation (e.g., interest, excitement, happiness, love, pride, appreciation, dedication). This shift is described as focusing on “main” (i.e., core) rather than “reactive” (i.e., stress-based) emotions.

4. *Evaluating thoughts to identify main thoughts versus reactive thoughts:* Building on the distinction between “stress reactive” and core (“main”) emotions, family members are assisted in cataloguing the thoughts that are driven by stress reactivity (i.e., a sense that something is wrong and must be fixed, stopped, or prevented) and recognizing or creating alternative or “reframed” thoughts that express their “main” (or core) beliefs, values, and hopes, and that enable them to shift from reactive to “main” emotion states. Rather than challenging the reactive thoughts as irrational or inappropriate, the potentially adaptive aspects of these thoughts are explored and used as the kernels from which to build or identify “main” thoughts that preserve the person’s core ideas, beliefs, hopes, or intentions but reduce the reflexive, threat-based, inflexible, and impulsive quality of the original “reactive” thoughts. In so doing, the therapist is family members’ role model for how cognitively to contain and reshape extreme emotions and thoughts, while using the sense of being “focused” as their shared goal (rather than seeking to reject or eliminate “dysfunctional” emotions or thoughts).

5. *Defining main goals (and distinguishing these from reactive goals):* Extending the stress-reactive versus self-regulated (“main”) emotions and thoughts to goals, FS/TARGET engages family members in a reexamination of their personal and collective goals to ensure that the goals reflect their core

priorities. Goals based on stress reactivity are examined and validated as adaptive if traumatic events occur, and the core goal(s) embedded in reactive goals are highlighted. Borrowing from multidimensional family therapy (Liddle et al., 2005), FS/TARGET therapists define therapeutic goals for each session in a behaviorally specific manner (e.g., What is specifically different for each client at the end of this session that reflects enhanced self-regulation?).

6. *Options for small positive steps toward the immediate main goal:* Again borrowing from multidimensional family therapy (Liddle et al., 2005), the FS/TARGET therapist helps family members to identify behaviorally specific actions they can take or paradigm shifts in their intentions or interpretations that provide each of them with a greater range of helpful emotions or behavioral choices (e.g., What goals are blocked or unrealized by current patterns of behavior or family interaction? What change does each client want, and how can he or she take a small but personally meaningful [to other family members as well as to him or her] behavioral or mental step toward that change?).

7. *Making a contribution:* How can family members recognize that by managing stress reactions in a self-regulated manner, they provide irreplaceable instrumental and moral support to every other family member, and often to other persons as well? It is crucial that children and parents recognize that they can be positive contributors to their family simply by handling stress reactivity in ways that increase the safety, trust, security, and hopefulness of other family members, and that parent(s) realize that they are “the medicine” (Liddle et al., 2005) when they assist their children in learning to self-regulate by serving as role models for self-regulation in the face of stressors.

### **Simulated Case Vignette Transcript**

To illustrate application of FS/TARGET to the treatment of youth with complex traumatic stress disorders, the following simulated case vignette provides a sample of interventions with a single mother, her 15-year-old daughter from a prior relationship, and her 4- and 8-year-old daughter and son from a more recent relationship that ended 6 months earlier, when the older daughter (M) reported an incident of physical assault by her stepfather. M was described by her mother as oppositional defiant at home since the age of 11. M accused her stepfather of emotional and sexual abuse at that age, but her mother had attributed the behavior to M’s “jealousy” toward her stepbrother and stepsister. M was born out of wedlock when her mother was 16 years old, and both lived with the maternal grandparents (with the truth of M’s parentage kept hidden) until her mother left home to marry M’s stepfather, when M was 6 years old, and brought the child with her. When therapy began, M’s mother had called the police numerous times because M had stolen from her, was associating with friends who used drugs, were several years older, and had dropped out of high school. Placement in a foster home was being recommended by the juvenile probation and child protective services professionals working with the family, because there had been no improvement in M’s “beyond parental

control” behavior, and M’s mother was fearful that M would get pregnant and run away to live with one of the young men with whom she associated.

After six initial assessment and stabilization sessions in which the therapist helped M and her mother to reframe their conflicts as mutually escalating stress reactivity, several altercations occurred between M and her mother, with the mother calling the police and M being arrested and placed in a juvenile detention facility. The following excerpts are from the next conjoint session:

THERAPIST: I’m glad to see you again after what I’m sure has been a stressful period for all of you.

MOTHER: (*Sighs, looks at M with a combination of annoyance and resignation.*) I don’t think my daughter really wants to be a part of this family. She just wants her own way.

M: (*Looks off into space with no expression, then looks down at her hands.*)

THERAPIST: I can see that you’re each in a reactive state, so we need to deal with the triggers for each of you right now to help you get back in focus. (*turning to the younger children*) How about if you two help us by showing us how you are good at being really focused with the books and art stuff over on this table? Could you do that? That’s great, we need you to just have fun and be really focused on whatever you like there, while your mom and M and I have a talk to help them get focused, too. So we’ll all work on being focused, and we’ll check in with you, so you two can show us how you do it, OK? (*Turns back to the mother, while M intently watches her younger brother and sister play.*) I can see how much you want M to be a part of this family, but I think your stress alarm is keeping you stuck in reactive feelings and thoughts. I can understand why you might be feeling very reactive, as a parent who loves your daughter and wants her to be safe and happy, and also not to make mistakes like ones that you feel you made at her age. Even though you’re certainly feeling some reactive feelings, including maybe feeling hurt or worried when you think that M isn’t going to be safe or be a part of the family, would it be fair to say that love and hope for M are your main feelings underneath? It must be hard to get to those main feelings, and main thoughts like what you value about M and your relationship with her, when you’re having these understandably strong reactions.

MOTHER: Well, wouldn’t any parent feel like this if she had a daughter who was disrespectful and selfish? She *is* making the same mistakes I made, and she’s just as pig-headed as I was when I thought I knew everything as a teenager. Look what happened to me!

THERAPIST: You want M to be open-minded and thoughtful about her choices, not stubbornly or impulsively doing things that aren’t really what she wants or needs. Sounds like that’s not easy for you to do, either, even now, so maybe it’s more that you and M both are very strong willed and

emotionally intense, and that can look “pig-headed” or impulsive, but it’s really just needing not to be controlled by your stress reactions. And you’re working very hard to stay focused on making a good life for yourself and your children. As a single, working mother, that’s a lot of stress—especially when you had to choose to protect your children instead of staying in your marriage—that took a lot of courage and a real focus on doing the right thing.

MOTHER: I know I should have ended that relationship a long time ago, when M said he was being abusive, but I just didn’t know what to do or who to believe. (*M looks up intently at her mother.*) I never wanted my daughter or any of my children hurt, but I didn’t know it was so bad, until the time when I left M with him while the kids and I visited my family. As soon as M told me what happened, I said that’s it, enough, he’s out. I won’t let anyone hurt my daughter. (*Looks tearfully at M.*) I wish she could stop being angry at me and accept that I really love her and will do whatever it takes so she’s OK.

THERAPIST: (*turning to M, who looks down and away again after a pause*) Is it a trigger for you when your mom says things that might sound like she thinks you’re the problem and maybe doesn’t want you to be in this family? I’m not hearing your mom saying that exactly, but that could be what you’re hearing now—or what you might have felt for a long time if you didn’t know how to get your mom to understand how bad things were.

M: (*Pauses, looks intently at her mother, who has her eyes closed, then looks down, nods yes.*)

THERAPIST: (*Turns to the younger children, who have stopped their previously active play and are looking wide-eyed at their mother and sister.*) Well this is some important stuff we’re talking about, and I see that you two want to be sure that it all gets worked out OK. I’ll make sure your mom and sister figure out how to make this OK, if you could just help by showing us how to focus again. That’s what I’m doing with your mom and sister, but since you two already are very good at focusing, it would be a very big help if you remind us how to be focused. You should focus on stuff that you like, like those books and toys and drawing, and that will help us focus really well on the talking we’re doing. How does that sound, is that a good plan, Mom? (*Mother refocuses on the younger children, smiles, and nods yes.*) Great, thanks, you guys, for being such a good help to us by showing us how you focus. (*The younger children smile and resume play.*) So I think maybe some of those really bad times are still bothering each of you, and you haven’t known how to get your focus, together as well as individually, back on your main feelings and thoughts and goals. There are two ways to do that: One is to take some time, not a lot, but some sessions, and just deal with the triggers and reactive emotions and thoughts that didn’t get dealt with entirely in past stressful situations. I can help you do that in a way that is hard work but doesn’t dredge up all

the old stuff—just the specific triggers and reactions that you don't want to be bothered by all the time now. I can do that privately with each of you and both of you together, but we'll need to do that when the younger kids aren't here, because it's really adult or young-adult talk and not something that they are old enough to be involved in. Is that something you'd each be willing to do with me, maybe in some sessions in the next several weeks?

MOTHER AND M: (*Silently look pensive, then sigh and look accepting, and nod yes.*)

THERAPIST: OK, the other way we can do right now, while you're both more focused than you were when we started—did you notice that? (*Pauses.*) You're both very good at getting focused when you just do an SOS—slow your thoughts down, get oriented to what's really important to you, and then start thinking or doing things that give you more personal control—and I see the younger kids are very good at focusing in their own way, too. (*Everyone looks over at the younger children, who are playing happily and intently.*) So what we can do to help you both deal with the triggers and reactive feelings and thoughts that are coming between you is to talk about a recent situation where you lost your focus, but we need to focus on figuring out the specific triggers right then for each of you, and how you tried to keep your focus, so you can do that again and maybe be able to succeed a little better in keeping your focus when something similar happens.

M: OK, how about the argument that happened between us last night, when M took my phone and then wouldn't admit it. After I told her I couldn't trust her if she kept doing that, she turned around and didn't get up to go to school this morning. How about that?

THERAPIST: (*Turns to M*) OK if we talk about that? Here are the ground rules: We're not just going to focus on what you did or didn't do. We'll include that, but we're also going to talk about how your mom got triggered and what she did or didn't do to be focused. The goal is for each of you to be able to keep your focus better, not to blame or punish anyone.

M: (*Looks at her mother, smiles.*) That would be different. I usually get blamed and punished.

MOTHER: (*Looks affronted, turns to the therapist, who calmly gives her a look of curious interest.*) I think a parent has to hold her daughter responsible and set limits. I don't call that blame and punishment. Am I supposed to just give up and let her do anything?

THERAPIST: You each make a good point. So it's important to M not to be blamed or punished, and it's important to Mom to be able to expect responsible behavior and set some limits. Those are good "main" goals, except M, I think that tells us more about what you don't want than what you do want in your relationship with your mom. If she isn't blaming or punishing you, do you just want her to let you do anything and totally leave you alone?

M: Sometimes, yes. (*Turns to Mom, smiles.*) But no, not really. I know I can't just do what I want all the time and I need to be responsible, but I try to do that and she doesn't notice except when she gets stressed out, and then I'm always the one she blames.

THERAPIST: So what's your main goal in your relationship with your mom and your life; what do you want her to do, and what do you want for yourself?

M: (*Pauses.*) I just want her to notice when I do good things, and not send me away. (*tears*)

MOTHER: (*tears*) That's what I want, too, really. I never want you to go away, and I know I need to be better at noticing what you do that's good, so you know I think you're great and I love you. I just get so stressed and worried. . . . I know I shouldn't have such high expectations for M. I do want her to be able to be a girl and not have to be an adult and miss out on all the fun and freedom of being a teenager, but these days that seems to mean doing things that kids never would have dreamed of when I was that age—smoking marijuana, staying out to all hours, having a car of her own. It's just not what I think is right—it's really dangerous for her because the drug use gets her depressed.

THERAPIST: Let's just slow down and take a moment to get focused, Mom. M seems very focused and is listening very carefully, so it's important that she hears your "main" feelings and goals right now, and that you do, too. The reactive feelings and thoughts are important, but we don't want them to take your focus away from what you really feel and want.

MOTHER: (*after an extended pause*) OK, you're right, it's just hard. M always thinks very deeply about things, and she says she understands why I worry, but that I should trust her and that I shouldn't try to keep her a child when she needs to grow up and be her own person. She's like me in that way; she wants her mom to trust her. And I want to, but I'm afraid I've failed her and, because of that, she's going to shut me out and just do whatever she wants—or thinks she has to—like I did when I was her age.

THERAPIST: So things happened to you when you were M's age or younger that made you feel unsafe or unprotected, and you shut people out and just did what you felt you had to.

MOTHER: (*Looks down, tearful.*) It's not something I talk about, and it was different back then. The expectations were different and some things could happen that you had to just keep secret. I thought I'd dealt with all that, and I don't want M to have that happen.

THERAPIST: Sometimes feelings from bad experiences can get triggered even if you've tried to put the memories behind you, and if that interferes with your focus when you really want to do the right thing—as a parent, or as a 15-year-old—and when you don't want it to turn into a conflict or hurt someone you care about, whether you're the daughter or the mother, then



you may have dealt with it very well but just did not quite finish by putting it all into focus so you know how to deal with triggers when they come up again now. I think that's what comes between you both now, more than anything else. M, do you sometimes have feelings or even memories that are from the past but all of a sudden can really bother you now? Maybe that's when you do things like taking stuff from your mom, which you know you shouldn't, and don't even really want, but those feelings can just take your focus away and you're not really choosing you're just reacting.

M: (*crying softly*) All the time, every day. I don't know why I do things like that when I really don't want to. I just feel like I have to do it, and I do. That's not really what I'm like. I'm not really a liar or a thief, but I just stop thinking and feeling when I do that.

THERAPIST: So even though you two are very different in some important ways, you share an ability not to just think but to care very deeply, and to know that those you love always are with you and won't let you down. We can work on that, if it makes sense to both of you that the challenge is to focus on what turns on your inner stress alarms, and deal with that, so you can be focused the way you want and really are capable of. That won't change everything, but it might give you back your most valuable resource: your ability to use your mind to focus, to make good decisions, and to feel good even when your stressed.

## Summary

In FS/TARGET, family members together learn skills for self-regulation. By identifying both types of functioning—the “reactive” and the “main” (regulated)—in therapeutic interactions and in daily experiences, FS/TARGET helps family members see that they have a shared and solvable challenge—to regain or maintain self-regulation—rather than separate, intractable dilemmas. FS/TARGET can include trauma memory reconstruction (as illustrated by preparatory comments by the therapist in the vignette), but the emphasis is on helping all family members use the FREEDOM foci to reexamine current and past experiences reflectively in a manner that models, provides guided practice, and leads to shifts in affective state that reinforce all family members' increasing commitment to achieve self-regulation.

## FAMILIES OVERCOMING AND COPING UNDER STRESS (FOCUS)

The FOCUS program is unique in providing a structured approach for delivering trauma-focused family therapy that is at once rich with detail and therapeutic activities, and sufficiently flexible to accommodate families of different ethnicity and culture who present with various levels of need and traumatic

stress disorder severity. A number of individual and family assessment measures are administered initially and throughout the treatment to monitor ongoing trauma and loss exposure; symptoms of posttraumatic distress; depression and anxiety; functional impairment; and family cohesion, support, and communication. These assessments help to specify the sequence and number of sessions needed to accomplish the program goals.

FOCUS is generally delivered over eight sessions: the first three sessions with the parent(s), the fourth and fifth sessions with the children, and the last three sessions with the entire family. The FOCUS program is not intended for crisis intervention and should be applied after acute stabilization has taken place. For example, in the case of medical, disaster, or other acute traumas, initial outreach is provided to the family in the hospital, and arrangements are made to meet after the immediate medical crisis has been resolved and ongoing or rehabilitative treatment is in place.

The FOCUS program aims to improve child outcomes (reducing posttraumatic stress, anxiety, and depression symptoms, while improving functioning in key domains) by targeting key intermediate outcomes, both familial (improve family communication and cohesion) and parental (improve communication and support between parents, facilitate consistent care routines and parenting practices, and maintain developmentally appropriate expectations for child reactivity and recovery). The model underlying this intervention, an integration of psychoeducational, narrative, and cognitive-behavioral theory, builds on previous research that demonstrates the potential of improving child adjustment by increasing family coping skills, promoting positive parenting skills, enhancing parent-child communication, and reducing parental emotional distress.

The FOCUS intervention is based on the earlier UCLA Trauma/Grief Program, which has been shown to reduce primary trauma-related symptoms and improve school and interpersonal functioning among participants (Saltzman et al., 2008). The FOCUS model also incorporates elements of an intervention for families with parental depression, which has shown both short- and long-term effectiveness in changing attitudes, behaviors, and interactions, and in reducing the long-term risk of mental health problems among children (Beardslee, Gladstone, Wright, & Cooper, 2003). The FOCUS model also incorporates portions of an intervention for HIV-affected mothers and their children, which has demonstrated improvements in emotional and behavioral adjustment and sustained, long-term improvements in key functional domains (Rotheram-Borus, Lee, & Lester, 2004). FOCUS has several core therapeutic elements: (1) psychoeducation regarding psychological trauma and developmentally appropriate expectations for children and adolescents, (2) enhancement of individual and family coping skills, and (3) development and sharing of individual and family psychological trauma narrative time lines.

### **Psychoeducation**

Prior studies have shown that trauma-focused psychoeducation including information about expected reactions to trauma and course of recovery, when

linked to coping skills enhancement, can help to ameliorate posttraumatic symptomatology in adolescents (Saltzman, Pynoos, Layne, Steinberg, & Aisenberg, 2001). In the current program, psychoeducation is provided separately and collectively to parents, children, and the family as a whole. Psychoeducation regarding trauma and loss is woven throughout all of the sessions in the guise of factual information, feedback from assessments, and activities designed to heighten personal and interpersonal awareness. Feedback is provided from initial and ongoing assessments of trauma history, symptoms, and functional indices for individual family members, along with measures of overall family functioning. Information on expected reactions to trauma based on age and developmental level is then customized to the family's specific symptom and functional profile, and prioritization of current concerns. Family members and the therapist then draw upon this information to craft family goals collaboratively. The therapist helps parents understand how family traumas or loss and parental distress may be linked to breakdowns in family cohesion, communication, care routines, and key parenting activities. On the positive side, family strengths, adaptive coping responses, and available resources are highlighted.

### **Individual and Family Coping Skills**

The FOCUS program is designed to identify and build on the strengths and adaptive coping strategies already present in the family. It starts by helping the parents and the family identify and prioritize current concerns, difficulties, and situations that evoke trauma-related reactions in one or more family member. Families then explore what they do individually and collectively to help themselves feel better and function better. This discussion begins an ongoing dialogue in which family members report on difficulties and trauma or loss reminders encountered during the week, and how they coped with them. The clinician also offers them new coping strategies to add to their existing "toolkit," such as relaxation and breathing techniques, communication and interpersonal awareness skills, cognitive techniques designed to interrupt distorted and harmful ways of thinking, and problem-solving strategies. Skills are learned in sessions and practiced in homework. Individual skills, built in an incremental fashion, focus first on monitoring and articulation of feeling states, on identifying the internal and external "triggers" or reminders that contribute to these changes, then on selecting one or more behavioral responses or strategies to deal productively with the distress.

### **Individual and Family Trauma Narrative Time Lines**

Perhaps the most novel element of the FOCUS program is having individual family members develop their own narratives of trauma or loss events and share them with the rest of the family through a graphic "time line." This exercise is important, because family members usually have different levels of exposure and experiences in traumatic events. This is true even if family members were all present during the same distressing events. Individual dis-

crepancies are based on differences in proximity and perceived threat, prior trauma and loss history, comorbid psychopathology, and gender and personality characteristics. These differences can be extreme when one family member has had severe trauma exposure (e.g., parental experience of combat trauma, or a child's experience of sexual or physical abuse).

As a result of their different experiences and reactions, family members typically have very different psychological needs and courses of recovery. These differences may lead to increased family conflict, decreased empathy and understanding between family members, and decreased family support and tolerance. This becomes especially problematic, because most families do not have in place mechanisms of discourse that permit open discussion and acknowledgment of these differences. In many cases, family members frame their silence as a way of protecting each other from worry or from what they perceive as an additional burden on family members who already are under duress. This was the case for a mother of a 16-year-old boy whose friend was shot while standing next to him at a bus stop after school. The boy and his family did not understand why their mother became increasingly anxious and depressed over the months following the incident, nor why she could not get out of bed and demanded to know her son's whereabouts at all times. During a family session 6 months after the shooting, the mother revealed that before she was married, she was standing next to her uncle when he was shot and killed during an armed robbery in a small downtown store. She had never told her husband or family about this experience and was insistent that she should not do so even now, when the memory and related fears were activated by her son's similar experience. Clearly, it was very important that the mother understand how her previous trauma heightened her reactions in the current case, and equally important that her family make sense of her seemingly extreme reactions, and be supportive of her very different course and timetable for recovery. Mutual understanding and appreciation of differences can reduce family stress, increase support, and foster individual and family recovery. As illustrated in the case example, only by bringing these discrepant experiences and reactions to family members' attention in an appropriate manner can the family resources be enlisted fully in the tasks of support and recovery.

To provide a safe and structured means for family members to develop and share their personal narratives within the family and, ultimately, to develop a consensual "family narrative" of the traumatic event(s), guidelines are developed for eliciting these narratives from children and adults. To facilitate the sharing and contrasting of experiences, a graphic approach using a "narrative time line" is developed. Parents and children (generally age 10 and older) are shown how to graph out their single or multiple trauma and loss experiences via a chart that shows time on the horizontal axis and intensity of distress on the vertical axis. Once instructed, clients are usually able to map their experiences on the time line themselves. Younger children are directed to use art and drawing to convey their experiences and to assemble their narrative on a game board that tracks chronology via a colorful and winding path. Parental

narratives are elicited during the first “parents only” sessions. In most cases, a parent learns new aspects of his or her partner’s objective and subjective experience from the narratives. It can also be helpful to use the narrative time line to track prior trauma and loss experiences that the parent or family has encountered. Helping parents appreciate the cumulative load of multiple or repeated stressful experiences can enhance understanding of the individual and family reactions to the current traumas. For example, in working with a family that had lost a daughter in a car accident, it was pivotal to track the prior experiences of both parents, who had endured serial hardships and traumatic events their country of origin, El Salvador, during the civil war, and during the course of their immigration to the United States.

During the latter parts of the parental sessions, the clinician focuses on the ways that differences in parental experiences and reactions, and subsequent misunderstandings, may contribute to current difficulties and breakdowns in marital communication and parenting tasks. In fact, by maintaining the primary focus on the family and on the children’s welfare rather than on marital issues, parents are much more open and willing to engage in the therapeutic work. It is also important to spend time preparing the parents for the family sessions. This involves clarifying which portions of the parental narratives should be shared with the children, how to respond appropriately to children’s questions and concerns, and how to take a leadership role in the family sessions via good listening and supportive engagement. Child narratives are elicited during the following two sessions by incorporating art and play activities to provide developmentally appropriate means of representing the children’s experience. In preparation for the family sessions, children are helped to identify the specific concerns and questions they want to discuss at that time.

The final sessions of the program are family meetings. After a summary of the major family traumatic events, usually provided by the clinician, the children are invited to share their narratives. The parents then comment and contrast their experiences of the same events. Later sessions are dedicated to discussing significant differences among family members regarding their experiences, perceptions, attributions, and reactions. As appropriate, any misattributions or distortions identified during the sharing of narratives, especially those regarding issues of blame, guilt, or shame, need to be addressed by the family. Structured activities are then used to help the family develop a consensual family narrative, and “healing theory” about the traumatic events (Figley, 1989). The final session is devoted to identifying, prioritizing, and engaging in family problem solving for current difficulties, and plans for upcoming and continuing family stressors.

## CONCLUSION

Family-based and family systems models for treating complex stress disorders are still in the formative stage of development, with much room for innovation

and a substantial need for scientific testing and validation (Walsh & Rothbaum, 2007). However, family-based therapeutic interventions (and couple therapy; Johnson & Courtois, Chapter 18, this volume) provide a unique way to address both the self-regulation (e.g., FS/TARGET) and trauma memory reconstruction (e.g., FOCUS) goals of recovery from complex traumatic stress disorders, while drawing upon, and enhancing, the ameliorative resources of the traumatized person's family and the traumatized family's internal and external support systems.

## REFERENCES

- Beardslee, W. R., Gladstone, T. R. G., Wright, E. J., & Cooper, A. B. (2003). A family-based approach to the prevention of depressive symptoms in children at risk: Evidence of parental and child change. *Pediatrics*, *112*, e119–e1310.
- Benjamin, L., & Benjamin, R. (1990). An overview of family treatment in dissociative disorders. *Dissociation*, *5*, 236–241.
- Brand, S., Engel, S., Canfield, R., & Yehuda, R. (2006). The effect of maternal PTSD following *in utero* trauma exposure on behavior and temperament in the 9-month-old infant. *Annals of the New York Academy of Sciences*, *1071*, 454–458.
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford Press.
- Courtois, C. A. (1988). *Healing the incest wound: Adult survivors in treatment*. New York: Norton.
- Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment*, *1*, 310–321.
- Deblinger, E., Mannarino, A., Cohen, J., & Steer, R. (2006). A follow-up study of a multisite, randomized, controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, *45*, 1474–1484.
- Diamond, G., & Josephson, A. (2005). Family-based treatment research: A 10-year update. *Journal of the American Academy of Child and Adolescent Psychiatry*, *44*(9), 872–887.
- Eyberg, S. M., & McDiarmid, M. D. (2005). Parent-child interaction therapy. In A. M. Gross & R. S. Drabman (Eds.), *Encyclopedia of behavior modification and cognitive-behavior therapy* (Vol. 2, pp. 940–944). Thousand Oaks, CA: Sage.
- Faust, J., & Katchen, L. B. (2004). Treatment of children with complicated posttraumatic stress reactions. *Psychotherapy: Theory, Research, Practice and Training*, *41*, 426–437.
- Figley, C. R. (1989). *Helping traumatized families*. San Francisco: Jossey-Bass.
- Ford, J. D., & Russo, E. (2006). A trauma-focused, present-centered, emotional self-regulation approach to integrated treatment for post-traumatic stress and addiction. *American Journal of Psychotherapy*, *60*, 335–355.
- Giaretto, H. (1982). *Integrated treatment of child sexual abuse*. Palo Alto, CA: Science & Behavior.

- Hawkins, S., & Manne, S. (2004). Family support in the aftermath of trauma. In D. R. Catherall (Ed.), *Handbook of stress, trauma and the family* (pp. 231–260). New York: Brunner/Routledge.
- Jordan, B. K., Marmar, C. R., Fairbank, J. A., Schlenger, W. E., Kulka, R. A., Hough, R. L., et al. (1992). Problems in families of male Vietnam veterans with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 60*, 916–926.
- Kazak, A., Alderfer, M., Streisand, R., Simms, S., Rourke, M., Barakat, L., et al. (2004). Treatment of posttraumatic stress symptoms in adolescent survivors of childhood cancer and their families. *Journal of Family Psychology, 18*, 493–504.
- Kazak, A., Simms, S., Alderfer, M., Rourke, M., Crump, T., McClure, K., et al. (2005). Feasibility and preliminary outcomes from a pilot study of a brief psychological intervention for families of children newly diagnosed with cancer. *Journal of Pediatric Psychology, 30*, 644–655.
- Kissane, D., McKenzie, M., Bloch, S., Moskowitz, C., McKenzie, D., & O’Neill, I. (2006). Family-focused grief therapy. *American Journal of Psychiatry, 163*, 1208–1218.
- Kolko, D. J. (1996). Clinical monitoring of treatment course in child physical abuse: Psychometric characteristics and treatment comparisons. *Child Abuse and Neglect, 20*(1), 23–43.
- Kreisman, J., & Kreisman, J. (2004). Marital and family treatment of borderline personality disorder. In M. McFarlane (Ed.), *Family treatment of personality disorders* (pp. 117–148). Binghamton, NY: Haworth Press.
- Layne, C. M., Beck, C., Rimmasch, H., Southwick, J., Moreno, M., & Hobfoll, S. (2008). Promoting “resilient” posttraumatic adjustment in childhood and beyond. In D. Brom, R. Pat-Horenczyk, & J. D. Ford (Eds.), *Treating traumatized children* (pp. 13–47). London: Routledge.
- Lebow, J., & Rekart, K. N. (2004). Research assessing couple and family therapies for posttraumatic stress disorder. In D. R. Catherall (Ed.), *Handbook of stress, trauma and the family* (pp. 261–279). New York: Brunner/Routledge.
- Liddle, H. A., Rodriguez, R. A., Dakof, G. A., Kanzki, E., & Marvel, F. A. (2005). Multi-dimensional family therapy. In J. Lebow (Ed.), *Handbook of clinical family therapy* (pp. 128–163). New York: Wiley.
- Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2006). Child–parent psychotherapy. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*, 913–918.
- Lieberman, A. F., Van Horn, P., & Ghosh Ippen, C. (2005). Toward evidence-based treatment: Child–parent psychotherapy with preschoolers exposed to marital violence. *Journal of American Academy of Child and Adolescent Psychiatry, 44*, 1241–1248.
- Madanes, C. (1990). *Sex, love, and violence*. New York: Norton.
- Maddock, J. W., & Larson, N. R. (1995). *Incestuous families*. New York: Norton.
- Meiser-Stedman, R. A., Yule, W., Dalgleish, T., Smith, P., & Glucksman, E. (2006). The role of the family in child and adolescent posttraumatic stress following attendance at an emergency department. *Journal of Pediatric Psychology, 31*, 397–402.
- Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University Press.
- Monson, C., Schnurr, P., Stevens, S., & Guthrie, K. (2004). Cognitive-behavioral couple’s treatment for posttraumatic stress disorder: Initial findings. *Journal of Traumatic Stress, 17*, 341–344.

- Pat-Horenczyk, R., Rabinowitz, M., Rice, A., & Tucker-Levin, A. (2008). The search for risk and protective factors in childhood PTSD. In D. Brom, R. Pat-Horenczyk, & J. D. Ford (Eds.), *Treating traumatized children* (pp. 51–71). London: Routledge.
- Riggs, D. S. (2000). Marital and family therapy. In E. B. Foa, T. M. Keane, & M. J. Friedman (Eds.), *Effective treatments for PTSD* (pp. 280–301). New York: Guilford Press.
- Rotheram-Borus, M. J., Lee, M., & Lester, P. (2004). Six year intervention outcomes for adolescent children of parents with HIV. *Archives of Pediatrics and Adolescent Medicine*, *158*, 742–748.
- Rotunda, R., O'Farrell, T., Murphy, M., & Babey, S. (2008). Behavioral couples therapy for comorbid substance use disorders and combat-related posttraumatic stress disorder among male veterans: An initial evaluation. *Addictive Behaviors*, *33*, 180–187.
- Ruscio, A. M., Weathers, F. W., King, L. A., & King, D. W. (2002). Male war-zone veterans' perceived relationships with their children. *Journal of Traumatic Stress*, *15*, 351–357.
- Saltzman, W. R., Babayon, Lester, P., Beardslee, W., & Pynoos R. S. (2008). Family-based treatments for child traumatic stress: A review and current innovations. In D. Brom, R. Pat-Horenczyk, & J. D. Ford (Eds.), *Treating traumatized children: Risk, resilience and recovery* (pp. 240–254). London: Routledge.
- Scheeringa, M. S., Salloum, A., Armberger, R., Weems, C., Amaya-Jackson, L., & Cohen, J. (2007). Feasibility and effectiveness of cognitive-behavioral therapy for posttraumatic stress disorder in preschool children. *Journal of Traumatic Stress*, *20*, 631–636.
- Schumm, J. A., Vranceanu, A., & Hobfoll, S. E. (2004). The ties that bind. In D. R. Catherall (Ed.), *Handbook of stress, trauma and the family* (pp. 33–50). New York: Brunner/Routledge.
- Smith, D. K., & Fisher, P. (2008). Family systems. In G. Reyes, J. D. Elhai, & J. D. Ford (Eds.), *Encyclopedia of psychological trauma* (pp. 277–278). Hoboken, NJ: Wiley.
- Stallard, P. (2006). Psychological interventions for post-traumatic reactions in children and young people: A review of randomised controlled trials. *Clinical Psychology Review*, *26*, 895–911.
- Timmer, S. G., Urquiza, A. J., Zebell, N. M., & McGrath, J. M. (2005). Parent-child interaction therapy: Application to maltreating parent-child dyads. *Child Abuse and Neglect*, *29*, 825–842.
- Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M., & Cicchetti, D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representation models: Implications for attachment theory. *Development and Psychopathology*, *14*, 877–908.
- Trepper, T., & Barrett, M. (1989). *Systemic treatment of incest*. New York: Brunner/Routledge.
- Walsh, S. S., & Rothbaum, B. O. (2007). Emerging treatments for PTSD. In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.), *Handbook of PTSD: Science and practice* (pp. 469–496). New York: Guilford Press.