Stemming the Tide of Trauma Systemically: The Role of Family Therapy

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The initial section of this article describes the frequency with which people are exposed to various forms of traumatic stressors and the limitations of linear thinking in both assessing and treating the consequences of traumatic exposure as reported by the Institute of Medicine. The middle section of the article identifies the research and theory that supports the utility of systemic thinking and action in working with traumatised systems, especially families. The final section includes an outline of a protocol for family therapists and other systems-informed practices to help trauma-tised families and other systems. A critical part of the protocol is that it meets the standards of trauma-informed practice reflected by the Green Cross Academy of Traumatology and the International Society of Traumatic Stress Studies (ISTSS) guidelines, and the six criteria for evaluating treatment approaches. These criteria include do no harm, exposure titration control, reciprocal inhibition tuning, quantity and quality of training, fit and fidelity, and evidence of effectiveness.

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Trauma is by nature interpersonal and is, therefore, a systemic entity. Trauma is defined here as an experience that is sudden and potentially deadly, often leaving lasting and troubling memories. As a result, either the experiencing or the re-experiencing affects and is affected by others. Most often the others are close friends or family. The traumatic experience creates memories that often are co-constructed through interpersonal interaction with others — either through seeking support or...
making meaning or both. The primary focus of linear treatment modalities (desen-
sitisation) is on the traumatised person who has primary traumatic reactions.

Equally important is addressing the secondary trauma in the traumatised
person's intimate support system that may result from initial notification about the
primary traumatic event (and subsequent medical treatments and/or psychologi-
cal/behaviour changes) and through the co-construction process. The linear modal-
ities do not address secondary traumatic reactions. Therefore, the traumatised person
who has a good result from linear treatment is surrounded by supporters who are
still traumatised (secondarily) themselves, and who remain ordered around the
traumatised person without benefit of reconstructing and processing through the
traumatic experience. ‘Stemming the tide of trauma systemically’ is managing the
adverse consequences using the principles of family therapy to treat both the
primary and secondary traumatic reactions.

The Emerging Concept of Trauma

The origin of trauma is from the Greek concept of ‘- - - - - ’ meaning ‘wound’.
The serious study of trauma can be traced to one of the first medical texts in which
the origin of hysteria is also found (Figley, 1985). Subsequently, trauma has been
within the purview of medicine and especially emergency and orthopaedic
medicine. Traumatology (the study of trauma, its effects and methods to modify the
effects) is a field exploding in terms of published works and expanding in terms of
scope. Gradually, interest in trauma evolved to include other medical specialties
especially psychiatry and then, most recently, to all of mental health, including
family therapy. Trauma psychology, for example, is a specialty area within the field
of psychology devoted to the study of the immediate and long-term psychosocial
effects of sudden, dangerous and overwhelming (traumatic) events. Trauma psychol-
ogy is the newest division (56) within the American Psychological Association,
established and officially approve by the Council of Representatives in 2008. The
American Association of Marriage and Family Therapists recognised that linear
modalities were not addressing the issues faced by the wider traumatised system,
and lobbied for approval to treat post-traumatic stress disorder (PTSD) in Veterans
Affairs settings. The latter department recognised the value of systemic treatment
and family therapists as a valued part of the treatment system.

However, in this century there has been growing attention to the far more
pervasive concept of trauma. The extended view of trauma embraces life and its
activities that are therefore relevant to all current disciplines and fields of study. This
includes, for example, history and trauma, with sociohistorical examination of long-
term effects and meanings of major traumas experienced by whole communities
and nations, both natural (e.g., Pompeii, Hurricane Katrina) and human-caused
(the Holocaust, 9/11) (Figley, 2009). The importance of trauma in understanding
business and economics is illustrated by the current 2009 world economy, In a
recent interview with the Wall Street Journal about the recent financial meltdown,
Fred Smith (Federal Express founder/CEO) noted, ‘Oh, the country is going to get
through this and the financial markets will stabilize … after going through a period
of trauma and readjustment’ (p. 7). This is an example of a broader use of the concept of trauma, in this case applied to financial markets during a particularly severe historical downturn.

In the special issue of *Traumatology* (Figley & Marks, 2008) focusing on Hurricane Katrina, each Tulane University faculty member described personal experiences and then identified the lessons learned from their experiences after Hurricane Katrina in New Orleans in the context of their respective disciplines. For example, in her essay, ‘Pompeii on the Mississippi: the View from New Orleans’, Susann Lusnia (Department of Classical Studies) draws from a historical framework as she examines past catastrophic events in urban areas and applies those lessons to make meaning out of what happened in New Orleans.

**Trauma as a Universal Human Experience**

The expanded interest in trauma makes sense because it is difficult in our modern world to avoid exposure to traumatic events. In addition to news reports, incidences of natural disasters, violence, abuse, and accidents, are World Health Organization (WHO) reports of traumatic events of individuals in harm’s way. However, there are few reports of indirect exposure. Segal and Figley (1985) found 96% of undergraduates exposed to a traumatic event; Resnick et al. (1993) found the lifetime exposures rate of traumatic event was 69%. However, Hepp et al. (2006) found 63.9% inconsistent reporting by adults. Thus, there is considerable range in reporting, but it is clear from what we know that trauma is universally experienced by most cultures, by both genders, and across all developmental stages.

**Trauma Lessons More Often Than Trauma Losses**

Even though the experience of trauma is universal, it does not mean that the effects are all negative. Most people have no unwanted consequences of trauma exposure and many gain valuable lessons. What has emerged in the current century, despite the impact of major catastrophes such as the recent bushfires in Victoria, Australia, the Indian Ocean tsunami, the terrorist attacks in New York and Washington, DC, and Hurricane Katrina and the levee failures in the US, is a growing recognition and appreciation of the resilience of the human spirit.

A good illustration of this trend is the emergence of the concept of posttraumatic growth. Tedeschi and Calhoun (1995, 1996) introduced the term in order to label the reports of people who claim to have benefited and personally grown from coping with the aftermath of traumatic events. Researchers have become more attracted to studying this experience that has been reported since antiquity.

**The Challenges of Treating Chronic PTSD**

Just as there is growing recognition of the opportunities for growth in the wake of trauma, today there is also great awareness of how difficult it is to eliminate or even effectively manage chronic PTSD with conventional (linear) methods. The U.S. Institute of Medicine (IOM), a part of the National Academies, completed a
comprehensive review of the scientific literature in evaluation and treatment of PTSD, with significant attention on military veteran populations (Institute of Medicine, 2007).

The IOM findings have led to considerable debate. However, most agree that the IOM findings provided an important wake-up call to the mental health community: that the leading current linear treatment methods (e.g., Eye Movement Desensitization and Reprocessing, cognitive–behavioural therapy, traumatic incident reduction) have severe limitations. Not surprisingly, the eight findings of the IOM suggest that fully understanding the interpersonal context and relational history of traumatised individuals is critical, that current established treatments of PTSD ignore the systemic approach emphasised by family therapists. This will be discussed later in this article.

First, at the most fundamental levels, IOM could find no generally accepted and used definition for recovery from PTSD under the linear treatment modalities. However, the often-posed question among family therapists to client families is: ‘How will we know when we are finished?’ The orientation for solution-focused family therapy is the resolution of the presenting problem. The IOM is suggesting that it is the opposite in the area of specialty focusing on treating PTSD; that most of the focus is on diagnosis and assessment and little attention to identifying, quantifying and measuring treatment success — from either the point of view of the practitioner or the client.

Second, the IOM review found that despite the fact that the diagnosis of PTSD has existed since 1980 its treatment has not received the level of research activity needed to support conclusions about the potential benefits of treatment modalities. It was noted in the Preface that they ‘could only conclude that well-designed research is needed to answer the key questions regarding the efficacy of treatment modalities in veterans’ (p. x). Perhaps such attention would have discovered that linear treatments that only focus on the traumatic event-related causes and the traumatic stress-related symptoms were ignoring the more complicated picture of circularity and interpersonal interactional causality. A more realistic understanding would attend to culture, family of origin, personality, relational, emotional and other dynamic and systemic factors. This understanding would naturally lead to approaches that have been embraced by family therapists for decades.

Third, the IOM found that even though the majority of drug studies were funded by pharmaceutical manufacturers, the results indicated that drug treatments are ineffective. This finding is not surprising to most mental health professionals including family therapists; that drugs contain symptoms and sometimes inadvertently cause side effects of more harm than good.

Fourth, with regard to challenging the notion that one sizes fits all and the importance of race and culture, IOM found that there were significant gaps in assessing the efficacy of interventions in important subpopulations of veterans with PTSD. They were especially critical of the lack of evidence in PTSD treatments when considering ethnicity, cultural minorities, women and older veteran clients. In the military this is of significant concern. For example, females are more vulnerable to PTSD and other anxiety disorders but are more willing to get treatment, and are
more responsive to treatment that is tailored to their particular needs. Females often turn to military life as a means to break out of abusive home environments. Prior unresolved traumatic experiences are a factor in how well a person will respond when faced with another traumatic event. In the male-dominated military culture, females are reluctant to report sexual harassment and sexual assault, in part because they do not believe they will receive the support they need to pursue legal remedy, nor receive the appropriate treatment for their trauma experience. Therefore, the approaches that are effective with males in the military may not be appropriate for females, and the military system itself may not meet the fit and fidelity criteria described later in this article.

Fifth, IOM found that research on treatment of PTSD in veterans is also inadequate in specificity of which treatment, in what context and for how long. In other words, the academy was not convinced that science has explained the relative importance of the setting–intervention interaction and the length of treatment–outcome interaction. The questions remain: where is the best place for treatment (outpatient versus inpatient versus early/crisis intervention) for how long and for which specific veteran demographic? The same kind of criticism could be applied to the treatment of most other mental disorders, whether it is systemic or not.

Sixth, IOM found a fatal disconnection between the needs of veteran clients presenting with PTSD and the clinical services delivered. More specifically, those studies of PTSD treatments have not systematically and comprehensively addressed the needs of veterans with respect to the efficacy of treatment and the comparative effectiveness of treatments in clinical use. This should be no surprise and is the fatal flaw of most linear mental health treatments: The assumed goal is simply the mitigation of symptoms. This is similar to the critical incident stress debriefing model, where the goal of the intervention is to return the person to duty as soon as possible, rather than address the deeper issues of meaning-making that may underlie the continuing traumatic reactions.

Based on IOM analysis, therefore, it is appropriate to challenge anyone who asserts that their method of treating PTSD or any consequent presenting problem involving trauma is the favoured treatment approach. Such pronouncements will be premature until science addresses the adequacies obvious in the literature. Thus, family therapists who have often avoided the pitfalls of absolutes and linear thinking, have a right to assert with as much confidence as any other field, that family systems treatments are tailored to the right clients in the right settings for the right length of time. That is, provided that the family therapists meet the quality and quantity of training criteria described below.

The Active Ingredient in Trauma Treatment: Systemic Meaning-Making

Although PTSD is often challenging to assess, treat, and prevent most people are resilient and ‘spontaneously recover’ over time; meaning-making emerges from discussion and reflection within an intimate, relational context. Barnes (2005) suggests that traumatised family members’ perceptions of the amount of stress caused by the traumatising event may have a greater impact on the family’s interac-
tion patterns, coping mechanisms and amount of emotional sequelae experienced than life stressors that are observable by others. In this respect, it is clearly the case that a family therapist working with a traumatised family must take the time to investigate each family member’s perceptions of what actually happened during and after the traumatic event, both to gain an understanding of the members’ ‘reality’ orientations associated with the impact of the event on their lives and to determine what options or resources the family members believe have been available to them as they have dealt with the crisis situation. Whether others perceive the event they have experienced as traumatic is not as important to the traumatised family members as their own perceptions of the event.

According to Shaw and Halliday (1992), families address crisis situations from either a mastery frame of reference or a fatalistic frame of reference. A family with a mastery orientation maintains the perception that family members have the resources, or access to resources, they need to exercise some control over the traumatic event. This often leads to solution-oriented thinking geared toward dealing with the crisis.

Figley (1988) has suggested that families who are able to recognise the strengths they have developed through their struggles following traumatic events are better able to recover from the experience of secondary trauma. A family with a fatalistic frame of reference maintains the perception that family members do not have access to the resources they need to deal with the trauma; this orientation promotes behaviour that enables the family to live passively with or be controlled by the crisis situation. Family therapists can intervene under these circumstances and bring forth a mastery level orientation to the problem or crisis.

Manne, Duhamel, and Redd (2000) found that mothers of children who had been diagnosed with cancer experienced greater PTSD symptoms when they felt inhibited in expressing cancer-related thoughts and feelings. This perceived lack of freedom to express thoughts and feelings made it difficult for these parents to find meaning in their situation or to obtain advice and coping assistance from others. Clearly, family members’ constraining beliefs (beliefs that restrict alternative views) about a crisis (Shaw & Halliday, 1992) may play as significant a role in the development of primary and secondary traumatic stress as the ‘traumatic’ event itself.

Such meaning-making or new reality emerges from answering the following fundamental questions of trauma experiences (Figley, 1989a, 1989b), even if the event involved only one family member who was in harm’s way:

• What happened to us?
• Why did it happen to us?
• Why did we act as we did during the crisis?
• Why are we acting like this since the event?
• Will we be okay if it happens again?

The answers to these fundamental trauma questions emerge from interpersonal interaction. Most often the context of such interaction is the family system. Family
empowerment therapy (Figley, 1989a) focuses specifically on enabling systems to not only ‘process’ the traumatic event but also learn from and make peace with the past by developing a family healing theory. This process is extremely reassuring to families as they cope with and eliminate their traumatic stress.

**The Family is Often the Trauma Antidote**

The fact of and process by which families manage traumatic memories and help make tolerable meaning has been known for many years and parallels the development of the field of family therapy. Family sociologist Reuben Hill was one of the first to recognise the role of the transmission of traumatic material from one family member to another, as described in his classic book *Families Under Stress* (1949). Hill studied World War II veterans as they returned home and went through the transition process of readapting to civilian lives, in particular the impacts of their postwar theatre experience on their families. Hill originated the concept of family stress. He was the first to suggest that the family system is greatly affected by crisis events such as war and natural disasters.

Willard Waller, a contemporary of Hill, also reported on the effects of the war on the family vis-à-vis the returning veteran. In his classic book *The Veteran Comes Back* (1944), he notes how returning veterans were glad to be home but felt bitter about having missed out on the many things their families had experienced while they were away; he also describes their feelings of returning as psychological immigrants in their own land. The feelings of disillusionment, confusion and sense of estrangement from family and friends noted by these sociologists more than 50 years ago ring true today as the troops returning from the war in Iraq and Afghanistan experience the same feelings. As the volume *Stress Disorders Among Vietnam Veterans* (Figley, 1978) shows, the disconnect between the experiences of the traumatised and their families who were spared direct trauma can have long-lasting effects on family relationships.

Yet to date there has been little overlap between the study of families and the study of trauma. Most traumatologists continue to focus primarily on individuals and largely ignore families, the social support they provide and mechanisms they develop for managing the emerging unwanted (or even wanted) consequences of traumatic events. Recently, however, some traumatologists have begun to recognise the secondary traumatic (systemic) effects that originate with individual family members and reverberate among their interpersonal networks. Similarly, marriage and family specialists, who traditionally abhor the limitations of viewing family issues in terms of linearity and individual functioning, have failed to recognise the parallel processes discussed in the traumatology literature. This has been true even when they have focused on common traumatic consequences of abuse, neglect, death and dying, and the various other calamities of life in the context of marital or family therapy. The newly expanding literature is rich in theory, research-based axioms and methodologies for effectively studying and treating the traumatised. It is our hope that this article can serve as a bridge between these areas of study.
The family is the context in which most traumatised people are relieved of their negative traumatic effects through meaning-making. There is a systemic solution to helping the traumatised. Family therapists are well positioned to be excellent trauma therapists. Posttraumatic family therapy helps families change unproductive ways of relating that have emerged during and following the traumatic event/crisis (Figley, 1989b). Family therapists, however, must be trauma-informed so that they ‘do no harm’ during the treatment process. Thus, it may be useful to discuss the ingredients of trauma-informed treatments.

**Ingredients of Trauma-informed Treatments**

What would be the ingredients that are critical for any psychotherapy for the traumatised? Recently, Figley (2008) presented the results of a review of the existing PTSD treatment approaches to determine not only what appears to work according to published outcome studies, but also what makes sense from the point of view of both the practitioner and the client seeking relief from their posttraumatic symptoms. The review of these dozen treatment approaches was guided by a set of criteria, the Figley PTSD Approaches Review. In addition to helping to judge the utility and relative worth of these competing PTSD treatment approaches, the Figley Review might provide a clearer picture of the effectiveness of different approaches and a more informed perspective from which to make treatment decisions in order to match the right treatment for the client at the right time and under the right circumstances.

The Figley Review utilises six criteria in assessing the utility of existing PTSD treatment approaches. These are drawn from the Green Cross Academy of Traumatology (1999), the International Society of Traumatic Stress Studies (ISTSS) guidelines, and reviews published in *Traumatology* (e.g., Dietrich, 2001). The six Figley Review criteria are: do no harm, exposure titration control, reciprocal inhibition tuning, quantity and quality of training, fit and fidelity, and evidence of effectiveness. Each criterion is explained below.

**Do no harm protection.** This criterion represents the presence of a treatment protocol that carefully protects the client from the harm of stressful memories of the trauma as much as possible. Such protection is high, for example, if the treatment protocol follows national treatment standards such as the Green Cross and ISTSS guidelines mentioned above. At the very minimum, trauma-informed therapy would include (a) the establishment of safety, (b) informed consent, (c) titration of exposure-related stress and (d) client self-soothing competence during and between treatment sessions. Regarding the latter, it is critical that the client is able to feel safe by being able to calm herself or himself. Unable to do so, they are likely to feel more vulnerable to feeling the classic symptoms of traumatic stress, particularly anxiety symptoms. As a result, the client will feel even more reluctant to remember and talk about the traumatic events.

**Exposure titration control.** This criterion is one of the most important since it suggests the treatment approach can help the client control the recall of the
traumatic memories and also modulate their reactivity to these memories. Exposure titration control is high if the treatment includes procedures to carefully control the topic (e.g., aspects of the traumatising experience) and the intensity (up or down) of remembering the trauma experiences in a way that meets the tolerance and preference of the client. This degree of control is especially important when clients are at either extreme: Where the client is especially vulnerable and feeling unsafe and memories of the traumatic event are experienced in large waves of emotion-laden thoughts. Conversely, where there is a breakthrough in the client’s treatment such as significant forgiveness of self and others and a readiness to remember everything that happened, a particular treatment approach (e.g., the use of metaphor or focusing on here-and-now experiences or desensitisation) might impede progress.

**Evidence of effectiveness.** This criterion is one of the only ones used today among traditionalists; it is based on carefully controlled outcome studies of the treatment approach. As noted earlier, in the case of PTSD treatment effectiveness, it is difficult to establish (IOM, 2007). Effectiveness is when there is evidence in various forms that the treatment approach is effectively addressing the client’s presenting problem. Thus, there is evidence that pre and posttreatment measures indicate the kind of change sought by the client and indications of client satisfaction.

**Reciprocal Inhibition Tuning (RIT).** The RIT is when the sympathetic nervous system response to the trauma (e.g., fear reactions and the release of adrenaline) is overridden or less powerful than the client’s parasympathetic nervous system (e.g., relaxation and the release of serotonin, as with reactions from laughter). When RIT is high the conditions are right for optimal desensitisation; the methods of relaxation are effective in the face of fear-inducing memories. There is sufficient exposure that activates the sympathetic branch of the nervous system while strategically stimulating the parasympathetic branch.

**Fit and Fidelity (FAF).** The FAF criterion represents the combination of a fit between the client’s needs and the treatment approach and between the practitioner’s preferences and the treatment approach. Fidelity is defined as the extent to which delivery of an intervention adheres to the protocol or program model originally developed (Holter, Teague, & Bybee, 2003); what is ‘advertised’ or presented by the practitioner is the same as the inventor/innovator and has been tested and found to be safe and effective. The FAF is high when there is not only high fidelity but also the treatment approach is one which the practitioner feels comfortable using and the client’s needs are provided for.

**Quantity and Quality of Training (QQT).** In the QQT criterion, there is a critical mass of high-quality training available that results in fidelity to the treatment approach as well as synergy between the trainer and trainees. This can generate a program of improvements in both training and the treatment approach. QQT is high when practitioners can access training that includes supervision and updates to insure effective treatment outcomes over time.
**Conclusion**

To stem the tide of trauma systemically is to respect the power of families to heal through family therapy. On the basis of available research we assert here that the family is the most important unit of intervention for helping the traumatized individual (Figley, 1989). Treatments should be systemic in considering the role of the family in conceptualising the trauma experience and alleviating symptoms of individual pain while working with family members to assist this healing process. At the same time it is critical to recognize and value the role of individualized treatment approaches, as long as they are compatible with understanding and respecting systems implications for those who love or live with the traumatized client.

Though Hill (1949) recognized that families are affected by stress, especially those stressors brought home by war veterans, families have been largely left out of the discussion of both stress and trauma in the last 70 years. Conceptually, trauma has evolved over the last century from a medical issue to one of universal human existence and expression. Understanding and treating the traumatized should be nested within the context of the family and ideally, that or some other like it should be the unit of intervention. Mental health practitioners who adopt a systems perspective are in the best position to help the traumatized because of their special familiarity with interpersonal relationships; understanding how these relationships contribute to both causing and mitigating traumatic responses.

**Endnote**

1 The extended view is especially relevant to family therapy, the newest mental health field and most often the most innovative because of the complexity of its clients.

**References**


