

FAMILIES AND PTSD

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The feminist philosopher, Sara Ruddick, has defined the primary parenting functions as preservation, nurturing, and training (24). From the point of view of affect theory, Donald Nathanson has talked about the vital parenting functions of affect modulation and cognitive education (21). When trauma effects a whole family or even a single member, the entire family partakes of the traumatic aftermath and the primary parenting functions of protecting, loving, and teaching become disturbed. Trauma stops the clock, producing developmental impasses in the traumatized family just as it does in the individual. Trauma disrupts attachment bonds and severs important internal and external connections (18, 26). The family becomes unable to adequately provide the safety, affective modulation, and training that its members require. Psychological trauma produces not just biological and psychological, but also social wounds and social wounds require social healing (5,6,17).

The effects of psychological trauma spread across and down through the generations like an infectious disease that is often difficult to diagnose because the presenting symptoms vary so widely. Although we cannot say which individual will manifest with precisely which symptoms, we can safely say that no member of a traumatized family escapes the nearness of death, horror, despair, or betrayal unscathed. Primate data as well as studies of various survivor groups provide us with well-documented evidence for the transgenerational traumatic patterns so well-recognized by clinicians (8,11,15,18,22,25,31).

Figley has written extensively about traumatized families (13,14). He has pointed out that families are effected in four ways: 1) simultaneous effects as when natural disaster hits an entire community; 2) vicarious

effects as when a family member is the victim of the trauma and the response of the other family members results in the experience of trauma, as in hostage situations; 3) chiasmal effects as when the traumatic stress actually "infects" other members of the family; and 4)intrafamilial trauma as when the family itself is the source of the trauma (13).

Clinicians working with traumatized and traumatizing families have noted certain key problems which include constricted intimacy and expressiveness, overt hostility with unpredictable verbal and physical aggression, and global maladjustments with recurrent crises (9). Many authors have focused on the primary difficulties in bonding with and remaining attached to children resulting in extremely dysfunctional family systems in which affect cannot be properly modulated, the capacity for empathy is greatly reduced, and traumatic reenactment becomes a routine occurrence (7,10,13,14,16,17,18,20). Nowhere are these dysfunctional family patterns so clearly demonstrated as in the incestuous family characterized by deceit, isolation, role confusion, boundary diffusion, triangulation, violence, and abusive power (10,16).

The result of the establishment of such reverberating and resonating patterns of family maladjustment is what Bentovim has termed a "trauma- organized system", a system focused on acting not talking or thinking (2). In such families, the original traumatic experiences cannot be touched, the silence must remain unbroken, the traumatic memories unexplored, the traumatic affect unmodulated. As in the individual victim of trauma, unresolved trauma leads to traumatic re-enactment in the entire family system, and if there are sufficient numbers of traumatized families in a larger system, it is reasonable to speculate that the result can be an entire cultural system within which unresolved traumatic experience sets the normative standards for family life (3,4,12,19).

Given the devastating effects of trauma on the individual family members and the family as a whole, effects that extend unpredictably into the future, therapy with the entire effected family is a vital intervention. The goals of treatment vary depending on the particular situation of each family, but certain general statements can be made. First, the victim is the primary priority. There are cases, particularly when children remain within the family system, in which protection of vulnerable family members must take precedence and the

perpetrator(s) of the trauma must be held accountable for their actions and prevented from inflicting further harm (2,10,16,17). As Herman has made clear, the establishment of safety is the first priority for any form of treatment and unless conditions of safety are achieved, treatment is doomed to failure (17).

Denial - both individual and social - always has been and continues to be a major barrier to recovery and must be addressed. This is particularly true since it is the most severe intrafamilial trauma that is most likely to be dissociated and/or denied, resulting in a systematic error (30). It has been repeatedly noted in multigenerational studies of child abuse that the parents most likely to abuse their own children are often those who have been abused themselves as children but who deny the abuse and idealize their own parents (22). The debate over "false memory" raises some important issues regarding the need for good clinical skills, but there can be little doubt that there has been a "false memory syndrome" noted for many years, and that on the part of the perpetrators of abuse who have a strong motivation to consciously or unconsciously deny their acts.

When the barrier of denial has been surmounted, the family must be helped to recapitulate the traumatic events allowing for the expression of dissociated affect, mutual validation and self-disclosure, and integration of the traumatic experience into a whole family story that looks backward into the past with a degree of compassion and forward into the future with hope (10,13,17). Sheinberg makes the point that framing the trauma, particularly when it has been intrafamilial, as the family's "shameful story", indicates implicitly that there are many other real and possible stories for the family to tell (28). Throughout this part of treatment the role of the therapist is largely one of educator and trainer, introducing a new cognitive frame for the family to utilize in their own healing based on a thorough understanding of trauma and its effects.

Benjamin and Benjamin see stopping the cycle of abuse as a fundamental goal for family intervention, our "responsibility to posterity" (1). Ideally, the outcome of family therapy is that the family is able to move past the traumatic experience, having integrated the trauma into a meaningful narrative as part of an overall family story. When this occurs, a family is able to move from a trauma-organized system to a system which is more flexible and responsive to the needs

of each individual member of the system in the present, rather than simply repeating a traumatic past.

Acute trauma is most damaging to a family system that is already dysfunctional. As in the individual, even a relatively minor stress can precipitate a crisis in a system burdened by longstanding intrafamilial and/or intergenerational trauma. In these situations, particularly with adult patients, there are often two family systems to be considered: the family-of-choice and the family-of-origin. Often the approach to each system must be handled quite differently.

For the adult who is the identified patient, the first focus of family intervention should usually be with the family-of-choice. It can be assumed that by the time the family member has entered intensive treatment for post-traumatic issues, the entire family system is experiencing both the vicarious and chiasmal effects of trauma. They will need extensive psychoeducation to provide them with a trauma-based cognitive framework within which they can reframe the family problem as a family challenge and survival mission. It is not unusual for violence to have entered this family system as well, and eliminating the violence must be a primary priority. The family members can be instructed towards understanding the role they are playing in a traumatic reenactment scenario and guided towards a redirection of the family script in a more satisfying direction. It is well known from work with various traumatized groups that social support is one of the few factors that attenuates trauma. Family therapy sessions can turn the energy of the family from traumatogenic to supportive once the healthier members of the family join together to provide what the identified patient actually needs rather than playing auxiliary roles in the patient's traumatic reenactment.

Working with the family-of-origin, particularly in those cases of longstanding intrafamilial abuse, poses particularly difficult problems that focus on issues of confrontation. Adults who have been victims of childhood abuse often attempt to precipitate a family confrontation shortly after entering treatment and recognizing their past history of abuse. Unless there is some risk of continued abuse, such early confrontations should be discouraged since it usually leads not to the outcome of reconciliation, validation, and support wished for by the patient, but instead to a dangerous traumatic reenactment that the patient often cannot tolerate (10,16,17,27). Family confrontations with

perpetrators or those who failed to protect can be extremely helpful to the patient in enabling him/her to speak the truth that has been hidden, renegotiate relationships, and validate his/her own experience. But such disclosure sessions will only be of value if they have been planned in advance and the patient is prepared for the negative consequences that may ensue.

It is particularly important that the therapist avoid being caught between the patient and his/her family as the surrogate rescuer, protector, defender. Learning to self-protect is a necessary outcome of treatment and the therapist must help the patient learn how to do it, not attempt to do it for him/her. Although the patient, with the support of the therapist, may be able to express predominant feelings of anger at the past abuse, one should never underestimate the strength of longstanding attachment bonds to the family-of-origin and the attendant and potentially dangerous grief should those bonds be unnecessarily or prematurely severed. Failure to take such attachment needs into account can result in a situation that is dangerous to patient, family, and therapist alike. Family confrontational work should occur, whenever possible, in the later stages of therapy when the patient no longer needs confirmation of the abuse and can tolerate the potential loss of attachment to the family (10,16,17,27).

There are significant challenges for the future. Since we recognize that trauma is intergenerational, what is our therapeutic responsibility to the previous and the future generation of each patient with whom we work? Every time we see a patient traumatized by intrafamilial abuse in a family context, we can reliably assume that we are in the room not with one post-traumatic victim but a roomful of them. How do we best balance the needs of the victimized child or adult with the needs of the victimized and victimizing family members? What is our responsibility when we know that the course of treatment for each victim may take years and meanwhile, their own children are being traumatized by their relatively poor parenting skills secondary to their inadequacies and disabilities? How do we develop a systems therapy technology that enables us to more radically, effectively, and quickly bring about total systems change to reduce the spread of this longstanding endemic traumatic "infection". Since families are the "cells" that comprise the "vital organs" we call nations, which make up the total body of humankind, the answers to these questions may have a significant determining effect on the future survival of us all.

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