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# Integrating a Trauma Lens into a Family Therapy Framework: Ten Principles for Family Therapists

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This paper aims to show how a trauma lens can be incorporated into existing family therapy practices, changing how therapists perceive presenting problems and therefore the issues and sites of intervention. After reviewing the family therapy literature concerning trauma and defining different types of trauma, the paper discusses how traumatic memories differ from ordinary memories. Ten principles for practice are described to guide therapists in integrating the trauma lens into their family therapy practice. Three case studies are used to illustrate these principles.

**Keywords:** trauma, family therapy, trauma processing, therapy principles

The therapeutic literature over the last decade has reflected a groundswell of interest in the topic of trauma, particularly in the neurobiology of trauma and various treatment approaches. Trauma therapy for the most part, however, is *individual* therapy, that is, the work is primarily with one person at a time, and, other than as a source of support, family members are not involved. Systemic family therapists conceptualise symptoms in terms of family interactions, prioritising family relationships rather than the individual as the primary site of intervention. Integrating trauma processing into family therapy is therefore complex because family therapy does not regard problems as confined to the individual.

This paper describes ten principles that can guide family therapists in integrating a trauma lens into family therapy practice. The aim is not to provide a new model of therapy, but to show that a trauma lens can be incorporated into existing family therapy practices, subtly and not so subtly changing both how therapists understand presenting problems and, consequently, the significant issues and sites of intervention.

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The premise underlying this approach is that, first, unresolved traumatic memories fuel behavioural or emotional problems and family conflict and, second, that family interactions often maintain or exacerbate the pain of traumatic memories.

### **Family Therapy and Trauma Literature**

A review of the literature on family therapy and trauma to the year 2000 (Riggs, 2000) reported that concerning trauma, family therapy was used in two ways. The first focused on the after-effects of an individual's experience of trauma, addressing the impact of the trauma on family relationships. The second on family therapy's role in assisting partners and other family members in helping the traumatised person heal. Although these trends continue, some family therapists also alternate between individual and family sessions. In individual sessions, they use *trauma-processing* methods such as Imaginal Exposure or Eye Movement Desensitisation and Reprocessing (EMDR) (Shapiro, Kaslow & Maxfield, 2007). In family sessions, they deal with the impact of the individual's trauma on relationships.

Depending on the type of trauma, family therapists may use whole family sessions to address and *process* the traumatic events experienced by one or more family member. Figley (2009) gave two reasons why it is better to keep the entire family together, arguing that, first, other family members may be vicariously traumatised by one of their member's traumatic experiences and, second, that the family has the potential to be an important source of support and validation for a traumatised member and may therefore provide the 'antidote' to the trauma (Figley, 2009, p. 179; 1988). We propose a third reason for family sessions, which will become apparent in this paper: for many young people the family is not only the antidote, but the *source* of the trauma as well.

Figley's (1988) 'Family Traumatic Stress Therapy' aims to rebuild rapport and trust among family members, promote self-disclosure and help the family develop a healing theory (p. 132). Of particular note is how the therapist encourages family members to speak about their personal experience of the impact of the trauma and to relegate negative views of self and others to effects of the trauma.

Other family therapy models deal with trauma by integrating trauma theory and techniques into their core skills. Emotionally Focused Therapy, for example, works with key attachment relationships in providing the security and safety needed for processing trauma related emotions. The therapist encourages the traumatised partner to revisit the trauma in his or her partner's presence, works with the partner's responses, and changes the couple's interactional patterns by identifying a 'critical sequence' that triggers the traumatised person. The therapy aims to help both partners regulate their emotional expression (Johnson, 2002; McIntosh & Johnson, 2008; Johnson, 1998; Greenman & Johnson, 2012). In working with traumatised children who have a psychiatric diagnosis, Goldfinch (2009) also incorporates an attachment and neurobiological lens, emphasising how family members' negative cycles of interaction can be changed through reducing interpersonal triggers and facilitating relationships.

Two other approaches, the 'Child-in Family Therapy' (Lander, 2011) and 'Existential Family Therapy' also involve family members talking to one another about traumatic memories and associated emotions. The Existential Family therapist helps

the individual recall traumatic memories through *telling* and *mastering* while helping family members *hold* and *honour* that individual's experience (Lance & Gyamerah, 2002; Lance & Raiz, 2003).

### **What is trauma?**

Because family therapists have always worked with families who have experienced hard times, how is working with *trauma* any different? To answer this question we need to first define trauma and traumatic memories. Trauma can be 'big-T' or 'small-t', simple or complex.

### **'Big-T' and 'little-t' Trauma**

'Big-T' traumas refer to exposure to highly disturbing situations, such as sexual and domestic violence or abuse, or a single experience of events, such as earthquakes and aftershocks, a bank holdup or car accident (McCullough, 2002). 'Big-T' traumas involve death, or the threat of death or serious injury, to which the person reacts with feelings of intense fear, helplessness, or horror. 'Big-T' traumas overwhelm the person's coping ability and meet one of the criteria for post-traumatic stress disorder (PTSD) (APA, 2000).

'Small-t' traumas, although not life-threatening, are highly disturbing events that evoke overwhelming negative affect and result in painful, unresolved memories, which negatively impact on the person's view of self and others. Most people have had several such experiences during their lifetime, with events that occur in childhood having the greatest emotional impact. Parental separation, being bullied or punished at school, the death of a pet are all events that can create 'small-t' traumas (McCullough, 2002). Psychological abuse, another 'small-t' trauma, is a core component of domestic violence and can be even more devastating than the 'Big-T' of physical abuse itself (James & MacKinnon, 2010; MacKinnon, 2008).

### **Simple or complex trauma events**

The terms *simple trauma* and *complex trauma* are sometimes used to distinguish between single incident trauma events that are circumscribed (simple) and those that involve many incidents where others were at fault, perpetrated, or did not act to protect (complex). In complex trauma, the victim of abuse is trapped and unable to escape the perpetrator for an extended period. Continuous torture, child abuse and domestic violence, where perpetrators are the people to whom the victim must continue to turn for protection, are all examples of complex trauma (Herman, 2003; Van der Kolk, McFarlane & Weisaeth, 1996).

Evolutionarily speaking, separation from the caregiver places infant primates at risk of death. Children can be traumatised by the experience of loss or separation from parents or by the parents' dangerous, fearful or fear inducing behaviour. When a child is seriously ill, both the parents and child may be left with traumatic memories of the illness or of witnessing or experiencing intrusive medical intervention.

All forms of child abuse are likely to leave a traumatic imprint on the brain, as does witnessing domestic violence (Perry, 2009, 2006). The child may be left with traumatic memories of the abuse itself, of the non-abusive parent's role in failing to protect and

of the negative reaction of others when the abuse was disclosed. Children's brains are in the process of dramatic development in the first few years of life and continue to develop into early adulthood (Schore & McIntosh, 2011). Traumatic events during childhood, particularly continuing adverse experiences of abuse or neglect, have an impact on the child's developing brain, creating structural changes that affect their subsequent ability to regulate affect, tolerate stress and inhibit behaviour (Perry, 2006).

Well-intentioned attempts by professionals to intervene with families where children are abused can also result in a cascade of changes for the child when they are removed from their parents and community, compounding the effects of the original trauma (Perry, 2006) and parents who themselves may have a trauma history can experience betrayal (MacKinnon, 1998).

### **Traumatic Memories and PTSD**

With good social support, human beings are resilient. Research has shown, for example, that the majority of people who survive a disaster will recover psychologically and have few if any symptoms (Galea, Nandi & Vlahov, 2005). Those who do not fully recover from traumatic events are left with *traumatic memories*, the partial or full recollection of which can be triggered by events in the current environment.

Traumatic memories differ from ordinary memories in that they are not processed by the brain as autobiographical narratives but remain as *undigested* memories in the form of pictures, sounds, smells and physical sensations (Briere & Scott, 2006). Often called *implicit memories* these undigested memories can be triggered when something in the current environment reminds the person of the original experience and can elicit a strong physical and emotional response, an overreaction to a cue in the current situation that resembles some aspect of the traumatic event, although the person might have no story or *explicit memory* of what is remembered.

These memories are recurrent and distressing and to avoid them the traumatised person may alternate between emotionally constricted states, where they feel detached from others, and times of feeling emotionally overwhelmed (Herman, 2002). Severity of symptoms correlates with the severity of the traumatic event. To meet the diagnostic criteria for PTSD, the traumatic event must be life threatening and the experience must overwhelm the person's ability to cope (APA, 2000). However, even when individuals do not meet the diagnostic criteria for PTSD, both single incident and complex traumatic events may underlie a range of presenting problems such as child behaviour problems, substance abuse, eating disorders, depression and underperformance at school or work.

### **The presenting problem and traumatic events**

The ease with which therapists can recognise the relationship between the presenting problem and traumatic events depends on both the therapist's organisational context and how the family presents the problem. Within acute health or mental health emergency services, families often present the traumatic incident and its effects as their primary concern, as is the case in the following example.

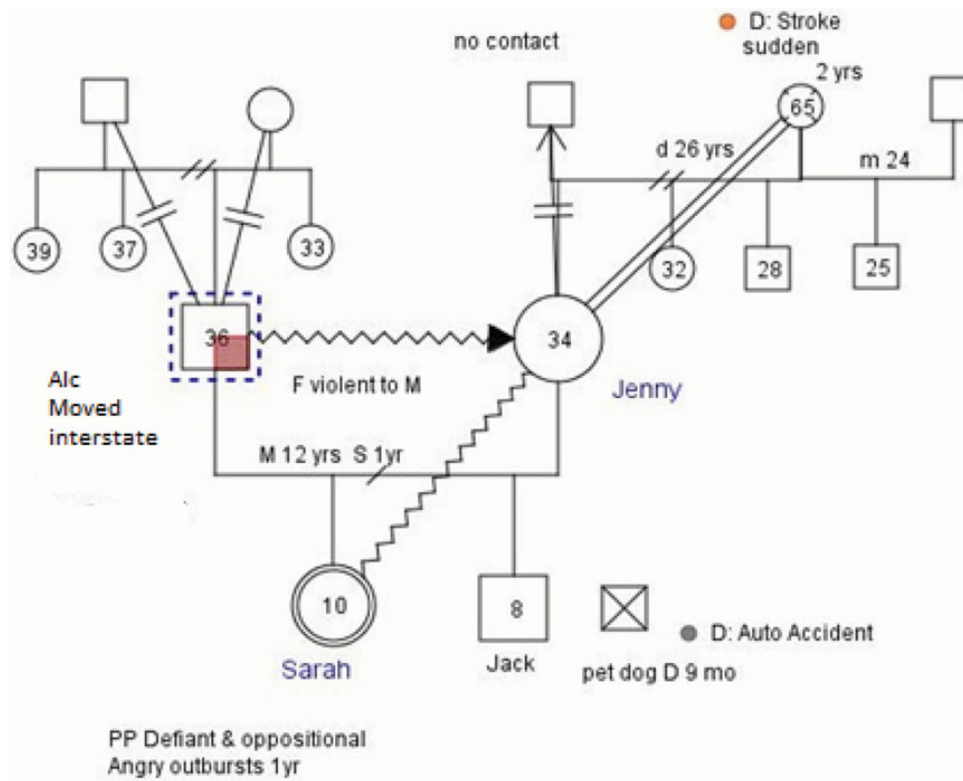
A mother contacted a mental health crisis service seeking help for her 16-year-old daughter who had become increasingly distressed over the past few days and was refusing to attend school. In the family interview, the parents seemed overwhelmed and unable to deal with their daughter's emotional distress. They said that the daughter had fallen apart after a family friend, a young man in his 20s, had sexually assaulted her three weeks earlier.

Within acute health or mental health contexts, it is easy to assume that the deterioration of family functioning is because of the impact of the traumatic event. What is difficult to determine is the degree to which pre-existing problems in the family created a vulnerability to the trauma or contributed to its intensity of impact. In the above example, one could assume that the parents' and daughter's distress was a natural response to the sexual assault. In this case, it took several sessions of family therapy before it became evident that the atmosphere at home before the assault had been tense, the parents had been in conflict with each other for many years and both were preoccupied with their relationship problems. Before the assault, the parents had not provided structure and support for their daughter and their younger children, had not monitored their children's whereabouts, and often left the children unattended. The family 'friend' had unsupervised access to the children and had taken advantage of this situation.

On the other hand, families may seek therapy from a family counselling organisation without mentioning a possible triggering traumatic event; instead, their primary motivation for treatment may solely be their concern with the behaviour of their child. It might have been months or even years after the traumatic event and the parents may not think the event is relevant. When the child's problem behaviour first emerged, the parents might have even attributed the change in behaviour to that adverse event. However, by the time they reach therapy, months or years later, the parents are angry, frustrated and more likely to see the child's behaviour as autonomous, separate from the events that precipitated it. Instead, they want help to manage conflict with the child — *We are fighting all the time*, or the child's problematic behaviour — *He is so naughty*, or anxious or depressed behaviour — *She cries all the time and won't go to school*.

It is therefore easy to overlook the possibility that unresolved memories of traumatic experiences may be contributing to current difficulties. If the therapist focuses on here and now problems, for example, developing communication skills, supporting parents to be firmer and more consistent in managing a defiant child, or helping parents set behavioural consequences, and, if in fact unresolved trauma is fuelling the family's difficulties, these interventions may work temporarily only to fall apart during times of stress when someone 'loses it'. Without an understanding of the underlying trauma, family therapists have no way to make sense of these treatment failures.

Jenny, a single-parent mother of two children [see genogram in Figure 1] sought family counselling to manage the behaviour of her 10-year-old daughter, Sarah, who was defiant and oppositional. The mother reported she had tried family counselling before and had learned strategies for being consistent in rules and consequences. Nevertheless, she was arguing even more with Sarah, whose bad tempered outbursts had become worse, often lasting for hours and ending in fits of hysterical crying. Apparently, in their first round of therapy, the connection between Sarah's behaviour and Sarah witnessing her father's violence to her mother had not been addressed.



**FIGURE 1**

(Colour online) Family "A"

In short, the relationship between the traumatic event, the presenting problem and the family's patterns of interaction may not initially be apparent. In contexts such as hospital or crisis services, where physical or psychological trauma is the presenting problem, it is important to hypothesise the connections among family members' responses to the current situation and any factors, especially those existing before the trauma, which may have created an increased vulnerability to either the trauma or its effects. In family counselling services, when a symptom or behaviour is presented as the problem, it is important to explore previous traumatic events and hypothesise about the relationship of traumatic memories to the current presenting problem.

### Ten principles for practice

In what follows, we propose ten principles to guide therapists in integrating a trauma lens into their family therapy practice. Three case studies are used to illustrate these principles.<sup>1</sup>

#### Principle One: First attend to safety

To benefit from therapy, family members must feel safe from harm within their family and community contexts as well as feel safe in the room with the therapist.

When a child or other family member is at risk of harm within the family or community, the therapist's first priority is to ensure the safety of that person. Ensuring

that children are safe may involve engaging child protection authorities or helping parents find ways of protecting both themselves and their children. In cases of child abuse or domestic violence, the perpetrator must be out of the home or the at-risk person must be in a protected environment. This means that 'therapy' is postponed until the therapist ensures that the person at-risk is protected. Throughout therapy, the therapist remains alert to any changes in the environment that might increase risk and vulnerability and attends to these issues (MacKinnon, 1998).

While attending to safety is always the first principle, in practice it is not always possible to completely assess risk in the first interview because family members may be reluctant to disclose information to a therapist they do not know or necessarily trust (Breckenridge & James, 2010). The therapist must remain alert to non-verbal signs of fear, or the intimidating behaviour or abuse of power of one family member towards another. The therapist can facilitate trust and a feeling of safety by engaging with family members, being clear about confidentiality and its limits, explaining the therapist's role and addressing family members' concerns about the therapist, the context of service or the nature of the therapy. When it is clear from referral information that the family, or family member, has experienced trauma, it is important for the therapist to ask during or at the end of the first session, *Do you feel safe with me here?*

**Principle Two: Make use of a roadmap: the trauma-focused genogram and a trauma list**

How do therapists begin to collect information about traumatic events in a way that is not time-consuming, does not degenerate into linear history taking and assessment and does not funnel the therapy down a simplistic cause/effect pathway? The answer is by working with trauma-focused genograms and trauma lists.

Genograms, a basic tool for family therapists, are visual maps of family relationships that capture the complexity of information concerning birth order, marriages, divorces and deaths (McGoldrick, Gerson, & Petry, 2008; Friedman, Rohrbaugh, & Krakauer, 1988). Using the engagement phase in the first session is the most efficient way to begin the trauma-focused genogram. This can be done organically while getting to know family members and before exploring the presenting problem. If left until later or until a future session, parents may perceive the therapist as postulating a lineal causal connection between the traumatic events and the problem.

While inquiring in a conversational way about where each parent grew up and where they fit within their sibling birth order, the therapist can introduce the genogram by asking: *Is it OK if I draw your family tree to keep track of what you are telling me?* The parents should feel the therapist's interest in family history is a process of *getting to know you* rather than an assessment or data collection or an implication of responsibility for the family's problems.

Drawing a genogram naturally leads the therapist to ask about immigration, relocation, ethnic or cultural backgrounds and to obtain approximate ages or dates for separation and divorce. The therapist may sensitively enquire about illnesses, mental illness, substance abuse, losses and deaths and whether deaths were sudden or prolonged, involved accidents or suicide. To capture traumatic events and themes over time, the genogram should depict three generations: children, parents and the parents' siblings, and the grandparents.

Age	Event	SUDS
4	Mum angry. Flipped out threw things	9
5	Dad bashing Mum. Blood all over Mum's face	8
7	Dad shot pet cat	9
7	Dad belting me, trying to get away	7
8	Moved school. Bullied by older kids.	6
8	Teacher letting the whole class laugh at me	5
9	Mum and stepfather arguing. Stepfather screaming, punching walls	6
12	Trying to protect Mum. Stepfather punching me	9
13	Waiting for stepfather to break into house where we were hiding	9
14	Grandmother died in car crash	7

**FIGURE 2**

Trauma List

Obtaining the genogram is not an end in itself; collecting a myriad of information detracts from a trauma focus or from exploring the presenting problem. Rather than a comprehensive depiction of family history, the genogram is a roadmap, a working document, not a static record to be filed and never consulted again. By continuing to add new information over time, the therapist can mentally flag possible traumatic events and hypothesise about the impact of these events.

Figure 1, family 'A' illustrates a genogram that captures several significant changes and losses: the sudden death of the grandmother from a heart attack, the parents' separation, the death of a family pet. The father had been violent to the mother, moved to another state and now had only phone contact with the children.

Another way of obtaining information about past traumas and how much they influence current behaviour is to construct a trauma list (See Figure 2). This is a common procedure in individual treatment approaches to trauma (Greenwald, 2007). With an adolescent or adult, the source of information is the person him or herself. For a younger child, the therapist obtains this information from the parent as well as from the child separately. It is important to devote an entire session to this activity, using the first two-thirds of the session to make a list of the worst experiences. Here is the trauma list obtained from 16-year-old Rowan whose case is described below.

Having obtained the list of events, the therapist then asks the client to rate each experience on a scale of 1 to 10 (the subjective unit of disturbance scale or SUDS). The number indicates the degree to which the client would feel disturbed if she or he were to talk about this event now (not how disturbing it was at the time the event occurred) (Greenwald, 2007). By devoting the last third of the session to list the clients' best experiences, including happy memories and achievements, the therapist helps the client leave the session focused on positive aspects of themselves and of their lives.

### **Principle Three: Traumatic events are located within a time and relationship sequence**

To reveal the connection between the presenting problem and prior traumatic events, a correlation must be made between the presenting problem and the nature and timing of adverse events family members have experienced. To do this, the therapist tracks the



onset and evolution of the problem, how family members responded to the problem behaviours or symptoms and how family relationships have changed before and after the traumatic event (James & MacKinnon, 2011).

**Principle Four: When the particular behaviour of one person *pushes the buttons* of another, exploring that person's heightened emotional reactivity may be a window into implicit memories of past trauma**

Another way to identify the existence of unresolved memories of past trauma is to observe the interactional process during the therapy session and be alert to critical sequences in which one person is affectively triggered by the behaviour — the words, the look, the tone, or the body language — of another family member. In the following example, the family sought therapy because of escalating conflict between the mother and her adolescent son, Rowan. The therapist directed them to talk to each other about their relationship during the session. Within a few minutes, the mother's voice conveyed a slight tone of irritation and Rowan raised his voice and shifted his body in his chair, turning away from his mother. The therapist interrupted the conversation.

Therapist: *What just happened, Rowan?*

Rowan: *I'm just standing up for myself.*

To unpack this moment and to discover what was pushing his buttons the therapist inquired more about his experience of his mother in that conversation.

Therapist: *What just happened that made you feel that you had to stand up for yourself?*

Rowan: *It's just that look she gives me. What's funny is I can be around anyone else in the outside world and I'm the complete opposite. I smile and I joke and I laugh and when I come back home it's like all the problems that represent who I am, I see it in people when I come back home.*

Mother: *In who?*

Rowan: *Well in you for one, I don't want to say . . .*

Mother: *Say what you need to say Rowan. This is the time and the place to say it.*

Rowan: *All right. You're an angry person and I still have some memories of you flipping out on occasions.*

Therapist: *What are some of those memories?*

Rowan: *All right, I'm going to have to go into full detail. When I was little, I remember Mum just flipping out one night and I was more scared than I've ever been. If I look back on when I was very little that's the thing that pops to mind, nothing else. So now I find that when Mum gets angry, yes, I'll overreact, I will stand up for myself.*

Mother: *I know the incident he's talking about and I really have to say it was a once-off incident. It wasn't his fault. I just lost the plot and started throwing things and screaming. I felt like I was going crazy and like I just couldn't cope with another day of this relentless responsibility and workload.*

Therapist: *What impact do you think that might have had on Rowan?*

Mother: *I don't want to be dissing what Rowan has said but he carries so much baggage. He carries these burdens and these memories and I'm worried that he will carry them into his future.*

Therapist: *How do you try to help him when you see him burdened with these memories?*

Mother: *I try to be logical and practical but I know that's not the answer. I say to him, 'Are you going to go through your whole life with this black cloud of bad memories hanging over your head, which you can't change?'*

Rowan: *What Mum doesn't get is that I just don't know how to deal with all this stuff that happened. So it's always there and now I don't know how to get rid of it. I don't know how to just let it go.*

Therapist: *So there is more stuff that happened.*

Rowan: *Yeah. A lot of stuff happened.*

Mother: *These kids were exposed to so much domestic violence. Rowan is carrying this burden and tends to tar people with the same brush and has massive trust issues.*

By observing the interactional pattern between Rowan and his mother and watching for the point at which Rowan became reactive, the therapist elicited an earlier memory that made sense of Rowan's reactivity. Opening up this conversation led to both Rowan and his mother disclosing other memories of traumatic events. In the next session, the therapist met with Rowan to obtain a relevant history of these events in the form a trauma list (see Figure 2).

**Principle Five: As traumatic experiences are ubiquitous, it is important to eliminate the possibility that unresolved traumatic memories are contributing to the presenting problem**

The fifth principle guides the therapist to routinely screen for trauma-related symptoms. Although this can be achieved by obtaining a trauma list for each person in the family, a more efficient way is to use standardised instruments to screen all new clients for symptoms of PTSD, anxiety and depression (Briere & Scott, 2006) and then to use a trauma list with each family member who scores in the clinical range. For example, when a mother is reactive to her adolescent son's behaviour, screening will help differentiate between a mother traumatised by violence she experienced from the boy's father and the mother who is depressed because of lack of social support.

Screening tools may be used as pre-treatment and post-treatment measures of symptom amelioration and change, as well as for providing information for making a referral to medical practitioners for possible pharmacological intervention. Several simple and readily available screening tools are available for clinicians to use with adults and children (see Appendix 1).

**Principle Six: Avoidance is the hallmark of PTSD. In an attempt to protect them, many parents avoid conversations with their children about traumatic events.**

This principle guides the therapist to identify times at which parents are avoiding conversations with their children about traumatic events and need help to enter this conversation and facilitate a healing dialogue.

In a situation where parents have experienced the same traumatic event as their child, they might also be avoiding their own traumatic memories. But often avoidance occurs because parents fear causing their children more distress or burdening them with their own pain or they may desire to protect their children from reminders of the trauma and help them 'move on'. Sometimes parents are unsure about boundaries or age appropriateness concerning how much information to give their child. The situation is especially complicated in situations of domestic violence or child abuse. Parents might have talked with their child at the time of the event, supporting the child emotionally and answering his or her questions. However, as a child matures, he or she may see events differently and another round of talks is in order.

In the following case example, Jamie, now aged twelve, was eight when his father died traumatically. Jamie suffered from mild cerebral palsy, which left him with muscle spasticity in his right leg and an impaired gait. He had difficulty making and keeping friends at the public school he attended. Jamie had recently discovered new information about his father's death, but had not told his mother. The mother herself wanted to avoid discussing the father's death, fearing that Jamie was 'too young'. His mother described Jamie as oppositional and aggressive, sometimes physically tormenting her by poking and harassing her until she said she wanted nothing to do with him. She said that his behaviour had become a problem over the last four years. She attributed his bad behaviour to the bullying he had experienced at school and to her difficulties in parenting an energetic and demanding boy on her own.

As the therapist drew the genogram during the first session, the mother said that Jamie's father had died four years earlier because of an accident in which he fell from a balcony. In the second session, the therapist met with Jamie alone to make a list of his 'worst experiences'. The therapist wanted to see how much Jamie's earlier experiences of having been bullied and the death of his father might still be contributing to his current behaviour. In this session, Jamie told the therapist a secret he had kept from his mother. A few months before this, he had found and read the police report, which said that his father had committed suicide.

In the third session, with the therapist's encouragement, Jamie told his mother that he had been snooping through boxes and had read the police report. When she scolded him for snooping, he put down his head and started to cry and she reached over and touched his head affectionately. What happened next was a *critical sequence* in which both participated in avoiding talking about the father's death.

Jamie: *Why? Why did he die?*

Mother: *I know, mate.*

He sat up and pushed her hand away.

Jamie: *But then you tell me that I have to get over it.*

Mother: *I never said that.*

Jamie: *Yes you did. You said I can't hide behind my father being dead...*

Mother: *No, I didn't.*

Jamie: *Yes, you did. You said I can't hide behind that as an excuse for my behaviour.*

Mother (raising her voice): *Listen, Jamie, it isn't an excuse! Okay?*

Jamie (raising his voice): *You told me to move on. Well I don't want to move on!*

Mother (voice raised): *Jamie, there was no excuse for that bad behaviour.*

In observing this interaction, the therapist was struck by Jamie's rejection of his mother's comfort. In this sequence — where Jamie began to talk about his father's death then, instead, instigated an argument with his mother that she bought into — they avoided the conversation they needed to have about his father. It was important the therapist kept them focused on the why and how of the father's death and the arousal of intense feelings, not just for Jamie but also for his mother, which were likely to accompany such a discussion.

Therapist: *Let me stop the two of you here.*

Therapist (turning to the mother): *Do you see how he is getting you angry to get you away from his tears? He gets sad. Then when you try to comfort him, he gets afraid of feeling sad*

*so he says something to you to get you to argue with him. And then he gets angry and doesn't have to feel sad.*

Jamie: *Yeah. That's the story of my life.*

Therapist: *Okay, so can we just go back to — Jamie, can you tell your mum what you're feeling sad about?*

Jamie: *I'm scared that when I am bad that you're going to want to get rid of me. So then I'm sad but I'm angry too. And I get more angry to try to get rid of that sad feeling that's stuck in me.*

Therapist (to mother): *What do you think Jamie is most sad about?*

Mother: *Well, about losing his father. My husband was very, very close to this boy. She paused. I don't want to talk about it with him here.*

Therapist: *Jamie, I'd like to help you and your mum have a conversation, a conversation where I help your mum help you stay with what you are feeling without it escalating into either of you getting angry.*

Jamie: *Yeah, cause I do that.*

Therapist: *You don't mean to but you get triggered.*

Jamie: *Yeah, it's just like a trigger.*

Therapist: *Can you tell your mum what you do know about how your dad died?*

Jamie (looking down at the floor): *I'd rather not talk about that.*

Therapist: *You know what? Probably all of us would rather not talk about it. But when you don't talk about it the feelings inside you build up.*

Jamie: *Okay. He died when he fell from a balcony.*

Therapist: *Can you tell us what you know about that?*

Jamie told the story of how he had come home from playing in the neighbourhood to see the blood soaked body of his father on the pavement and how the police and ambulance came and took him away. As he finished speaking, he turned back to his mother and said: *Have I got that right? Is any of that fake?*

Mother (to the therapist): *Isn't he too young for all this?*

Therapist: *No. He needs to tell you what he knows. What he says, are those the facts? He wants to know if it's fake?*

Mother: *No it isn't fake. Those are the facts.*

Jamie: *Did he die right away or at the hospital?*

Mother: *In the hospital.*

Jamie: *Did he die because his head was smashed or because he didn't have any blood left?*

Mother: *He died of the head injuries.*

In the above sequence, both Jamie and his mother made several bids to avoid the painful discussion about the father's death — *I'd rather not talk about that* — *I don't want to talk about it with him here* — *Isn't he too young for all this?* The therapist ignored these bids and with gentle persistence kept the mother and son talking.

Principle six emphasises the importance of the therapist becoming aware of what is not being said. Sometimes this is the 'elephant in the room'. Without this awareness, therapists will succumb to the suction of colluding with family members' avoidance by either not raising the topic or by giving up when family members resist the therapist's efforts to remain focused.

**Principle Seven: Unresolved traumatic memories have negative cognitions at their core**

Experiencing overwhelming trauma shatters trust in oneself, others and the safety of the world. Negative thoughts that arise from traumatic experiences continue to fuel the survivors' negative affective states of anxiety, depression, fear and anger. Core negative cognitions centre around themes of vulnerability — *I am vulnerable* — *I am weak* — *I am powerless*; themes of worthlessness — *I am bad* — *I am a failure*; themes of defectiveness — *I am unlovable* — *I am damaged*; and, last, themes of responsibility — *It's my fault* — *I am to blame*. These are the negative lessons learned from trauma and the goal of therapy is to identify, explore and change these lessons and the accompanying affects (Greenwald, 2005; Greenwald, 2007; Shapiro, 2001).

As the conversation between Jamie and his mother continued, Jamie revealed his negative core beliefs about his father's death and how these beliefs had changed over time.

Therapist: *Can you tell your mum what you used to think, because it sounds like you used to think one thing and you've changed your mind?*

Jamie: *I used to think that you killed him. I didn't know that someone could kill himself. I just thought that other people kill people. So when I thought you killed him, I got angry.*

Therapist: *Can you tell your mum what it is about that that made you angry?*

Jamie: *That he died. It used to be a family. And then there was no father and now there is half a father because there is a stepfather. I used to think, 'well if you killed my father then you should be dead'. That's what I thought until I read the police report.*

Therapist: *Tell your mum what you thought after you read the police report.*

Jamie: *After I read it I thought, 'Well, hang on you didn't kill him. My dad did it himself. He killed himself. It was suicide'.*

Therapist: *Tell your mum what your idea is about why your dad committed suicide.*

Jamie: *He hated me and he just didn't want to be around me anymore and all the trouble that I caused. That's why he killed himself.*

Mother: *So you blame yourself, you think it's your fault?*

Jamie: *Well you didn't do anything bad. It was me he didn't want to be around because I'm spastic, that's what I reckon. It's all my fault.*

Therapist: *And do you still think that's true?*

Jamie: *Yeah. Just cause he hated me. That's all.*

Therapist to mother: *Did you know he thought that?*

Mother: *I thought he might have blamed himself but I thought he was too young to talk about it.*

Therapist: *Do you think it's true that his father killed himself to get away from Jamie?*

Mother: *No, not at all!*

Therapist: *From what you know about Jamie's relationship with his father, do you think it was the kind of relationship in which a father was sick of his son and wanted to get away from him?*

Mother: *No, not at all. Jamie, Dad idolized you. You know that.*

Until that moment in his life, Jamie had not ever talked to anyone about why his father had died. Possibly, he had never even articulated to himself what he disclosed in this session. However, his unarticulated, disturbing thoughts would have been contributing to his self-hatred and aggressive behaviour. This conversation allowed Jamie and his mother to examine his negative core cognitions and challenge them.

Principle seven emphasises the point that the traumatic memory is interlaced with negative cognitions and a key aspect of therapy must be to bring these cognitions to light. For children, the best person with whom to reveal these cognitions and to have them challenged is their primary attachment figure.

**Principle Eight: Implicit memories become less disturbing when they are processed and transformed into explicit, narrative memories**

Although Jamie could tell the story of his father's death, in other situations children experience traumatic events and are left with implicit memories but no story of what has happened. Without the story, they cannot make sense of disturbing images, flashbacks and physical sensations. To make sense of what is happening to them children need their parents to tell the narrative of the traumatic event.

In the next case example, the mother told ten-year-old Sarah the story of why her father left the family. The mother had sought therapy for help in managing Sarah's defiance and oppositional behaviour. She said that she could not have a conversation with Sarah without Sarah exploding into angry outbursts. When asked whether specific things were more likely to result in Sarah exploding, her mother said that talking about her father made it worse. The mother agreed that a goal for the session would be for her to talk to Sarah about her dad without Sarah exploding.

In responding to the therapist's questions about their relationship, both Sarah and her mother agreed that they argued more than other mothers and daughters. At one time, they had been close, but not since the father had left. This led the therapist to explore with the mother the changes in their relationship around the time that the father left the family.

Therapist: *So something about her dad leaving has changed your relationship?*

Mother: *Yeah. I think it first started because she had a lot of anger and blame towards me. She has just pushed me away.*

Therapist: *She thought it was your fault that he left?*

Mother: *Yeah.*

Therapist: *And what did she say you did?*

Mother: *That I kicked him out. That I made him go away.*

As the mother talked about the father, a tear rolled down Sarah's cheek.

Therapist: *What do you think her tears are about?*

Mother: *Talking about her dad.* The mother reached over and pulled Sarah's chair closer to her.

Therapist: *What do you think happens inside her?*

Mother: *She doesn't like me talking about her dad. It's hard for me to explain to her that a lot of things that her dad did were wrong.* The mother pulled Sarah's chair closer to hers and put her arm around her.

Therapist: *Sarah, when we talk about your dad, does it make you miss him?*

Sarah nodded yes.

Therapist: *What do you know about why your dad is not living with your family now?*

She shrugged.

Mother: *It's okay. You're allowed to say.*

Sarah: *I don't want to.*

Mother: *Why?*

Sarah: *Because.*

Therapist: *What you think happens for her?*

Mother: *I know she misses him a lot.*

Therapist: *Do you think she would feel it would be disloyal to say?*

Mother: *Yeah. She does feel like she's betraying him. She knows why he left. But she feels like she's betraying him if she says it.*

The therapist talked for a while with the mother about the good side of the father. The mother spoke about how he used to play with the children, taking them to the beach and playing cricket in the backyard. This positive description of the father paved the way for the mother to tell the story about the traumatic events that led to the father leaving the home. Although Sarah witnessed these events with her own eyes and thus would have had many implicit memories, she had no coherent narrative memory to make sense of her explosive feelings.

Therapist: *Let's just see what happens when you talk to her about why her dad is not living with you right now. And I will help you with that as it unfolds.*

Mother: *Okay.*

Mother (turning to Sarah): *I'm not quite sure what happened to Dad. Dad started drinking, which made him do a lot of things that he didn't used to do before and then when Mum tried to talk to Dad to try to get some help, Dad wouldn't get help. And then we argued about it and they became fights and it became unsafe.*

As the above transcript illustrates, helping the parent to tell the trauma story to the child may not be straightforward. The parent or the child or both may change the subject, refuse to cooperate, or become upset or angry. The therapist's job is to persist gently but firmly, finding a way to make this conversation happen.

**Principle Nine: The retelling of traumatic events is often accompanied by the cathartic release of strong affect**

A traumatised person will sometimes split off the disturbing feelings and memories to cope. In doing so, the person also shuts down emotionally and becomes detached from those close to them. When retelling the traumatic events this 'wall' may come down and the suppressed strong affect will emerge in a cathartic form. At this point, the therapist must have the courage to stay with that affect and allow it to run its course rather than changing the topic to something less upsetting. The therapist intensifies the focus to elicit the affect then pauses where the affect seems to exceed the *window of tolerance* (Briere & Scott, 2006), then returns to focus again.

As her mother was speaking, Sarah started to cry in jagged, gasping breaths. The therapist was concerned for Sarah but knew that it was important to continue the process and allow the intensity of the affect to take its course.

Therapist: *What do you remember, Sarah?*

Sarah: *Dad. I just feel so upset when she talks about that.*

Therapist: *Does it bring back bad memories?*

Sarah: *Yeah.*

For the next few minutes, both the mother and Sarah sobbed heavily. The therapist paused and waited. When their sobbing subsided, the therapist pressed on.

Therapist: *Tell her the rest now. Her dad had started drinking. And he changed. Tell her a bit more of the rest.*

Mother: *Then Daddy hit mommy. He hit me and he pushed me. It was a horrible thing. I was very, very scared that Dad would do something to me and then I wouldn't be able to look after you. Then who would look after you? Because Daddy was supposed to look after all of us. But he didn't.*

Both Sarah and her mother sobbed again. When their sobbing calmed, the therapist pressed on.

Therapist: *Tell her what happened next.*

Mother: *Then I had to call the police. Then the police came around and they arrested him and he had to go to court.*

Sarah stared ahead again, sobbing, this time as if hyperventilating, tears running down her face. Her mother reached out for Sarah's hand, but Sarah pushed her away, looking at her angrily.

Therapist: *Keep going.*

Mother: *Then Daddy couldn't come back home again.*

Therapist to Sarah: *You feel angry that your Dad went away. Angry and sad.*

Sarah did not answer and continued to breathe heavily, constricted, heavy sobs, the tears covering her face. She did not brush them away.

Therapist to mother: *What would she remember? Did she see or hear any part of that?*

Mother: *She saw him hit me. She saw him throw things around the house. She probably heard more things than she saw.*

Therapist: *Was she scared?*

Mother: *Yeah.*

Therapist: *Did she try to do anything?*

Mother: *Yeah. She yelled at him. She tried to stop him.*

Therapist: *She was scared and brave.*

The mother nodded yes and she started to cry intensely again. The therapist waited a few moments.

Therapist (to mother): *It brings back bad memories for you too. You're both very sad.*

Therapist (to Sarah): *Do you wish that your dad hadn't left the family?*

Sarah nodded yes and then brushed the tears away from her wet face with the back of her hand.

Therapist (to mother): *You must wish that all of this hadn't happened.*

Mother nodded yes and then put her arms around Sarah.

Mother: *I'm sorry. This is not the way I wanted things to be.*

Sarah (raising her voice, angrily): *But she always said it's Dad's fault not her fault. So why is she sorry now when she says it's Dad's fault?*

Mother (raising her voice): *It's not my fault. I'm sorry because this is not how I wanted your life to be and I'm sorry about that, even though it's not my fault.*

Therapist to Sarah: *Is part of you angry with her for making your dad go?*

Sarah nodded yes.

Therapist: *Can part of you understand why she made your dad go?*



Sarah: *There's a little part that understands that she had to make him go.*

Therapist: *But there's a big part that... what?*

Sarah: *That thinks dad should've stayed.*

Therapist: *You feel so bad that you wish he was back even though it was dangerous when he was here.*

Sarah nodded. She took a tissue, wiped the tears from her eyes and stopped crying.

Therapist: *Is there more, Sarah, that you need to say to your mum?*

Sarah: *Why does she always say things after Dad phones? Why does she always ask me so many questions?*

For the remainder of the interview Sarah and her mother discussed the father's phone calls and the mother agreed not to interrogate her after the father had phoned. By the end of the interview, Sarah was leaning into her mother's arms. Two weeks later the mother reported Sarah's behaviour had changed dramatically since the session. She was more cooperative, had had no more temper outbursts and seemed happier.

It takes courage, experience and skill, for therapists to stay with intense affect and let it unfold, while keeping the process within the clients' window of tolerance. Therapists may experience strong suction (both from clients and from within themselves) to change the topic to something less upsetting. The task of the therapist is to block the client's avoidance thus increasing affect while monitoring for hyper-arousal that would indicate the need for a temporary decrease in intensity.

**Principle Ten: Pay attention to the impact on oneself of hearing stories of traumatic events and witnessing intense distress. Understand, care for and heal oneself**

When regularly hearing the stories of clients who have been traumatised, therapists themselves may develop trauma-related symptoms. In the literature, this is known under various terms including vicarious traumatisation, compassion fatigue and secondary traumatic stress (Bride, Radey, & Figley, 2007; Sabin-Farrell & Turpin, 2003). Symptoms include: heightened emotional reactions when working with clients including intense feelings of sadness, depression, anxiety, fear, guilt, anger, shame; somatic complaints including difficulty concentrating and hyper-vigilance; numbing and avoidance especially concerning violence; and intrusive images of clients' stories, including nightmares and flashbacks (Todd, 2007).

One of the important indicators of vicarious trauma is that the therapist feels a heightened sense of vulnerability and of the fragility of life and experiences a shift in cognition, becomes suspicious of others, more cynical or distrustful, or develops cynical or pessimistic views of human nature, clients, or about the work of therapy (McCann & Pearlman, 1990).

The implications for therapists working with traumatised clients are clear: find ways to take care of yourself. Ensure you have supportive supervision that helps you develop skills as well as offers you a place to discuss your personal reactions. Monitor your emotional reactivity and participate in a peer group of other therapists, who keep a watchful and caring eye on one another.

The likely mechanism responsible for vicarious trauma is the clinician's empathy for the feelings of the client at the time of the trauma (Sabin-Farrell & Turpin, 2003). Clinicians susceptible to vicarious trauma feel empathy as sympathy. Those

who are able to maintain *clinical empathy* as attuned curiosity and imagining about the client's unique experience, without becoming emotionally triggered, seem to fare better (Sabin-Farrell & Turpin, 2003).

The ability to maintain clinical empathy and not fall into sympathy may be due in part to training and the utilised model of therapy. Therapeutic approaches that involve the client telling the entire story to the therapist, perhaps several times, are more likely to emotionally trigger therapists. Approaches that structure the session and are less conversational between the therapist and client are probably less likely to elicit sympathy. When the therapist has a clear roadmap, a focus, and objective for therapy, clinical empathy rather than sympathy, may be a natural by-product.

When aspects of a client's story resonate with the therapist's own life story, the therapist is most likely to respond emotionally. Therapists are therefore more vulnerable to vicarious trauma when they have a reservoir of unresolved traumatic memories and easily get their 'buttons pushed' when listening to clients' stories. Trauma is ubiquitous. It happens to all of us. As therapists reaching out to those who have been traumatised, we must also find ways to heal ourselves.

## Conclusion

In this paper, we have defined trauma and illustrated how the context and presenting problem influence whether and how therapists perceive traumatic events. Ten principles for integrating a trauma lens into a family therapy framework have been presented.

In summary, the trauma focused genogram and the trauma list can guide therapists in identifying the impact of traumatic memories. Standardised assessment measures also provide a way of routinely screening for the influence of past trauma on current behaviours. Because avoidance is the hallmark of trauma, therapists must remain alert to family members' avoidance of important topics of conversation and skilfully facilitate these needed dialogues. During these dialogues, the therapist is alert to negative cognitions and monitors the level of affect to keep it within a window of tolerance.

The final principle addresses the impact on the therapist of hearing disturbing stories and witnessing intense affect and encourages therapists to monitor this impact, seek support, and develop a deeper understanding of their own responses.

## Endnote

- <sup>1</sup> These cases are a compilation of several cases. Names and identifying information have been changed and any similarities to actual families are coincidental.

## References

- APA (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th Edition, p. 943). American Psychiatric Association. Retrieved from <http://allpsych.com/disorders/dsm.html>

- Breckenridge, J., & James, K. (2010). Thinking about homicide risk: A practice framework for counselling. Stakeholder Paper, No. 9 *Australian Domestic and Family Violence Clearinghouse*.
- Bride, E., Radey, M., & Figley, C. (2007). Measuring compassion fatigue. *Clinical Social Work Journal*, 35, 155–163.
- Briere, J., & Scott, C. (2006). *Principles of Trauma Therapy*. Thousand Oaks, CA: Sage Publications Inc.
- Friedman, H., Rohrbaugh, M. & Krakauer, S. (1988). The time-line genogram: Highlighting temporal aspects of relationships. *Family Process*, 27, 294–303.
- Figley, C. (1988). A five-phase treatment of post-traumatic stress disorder in families. *Journal of Traumatic Stress*, 1(1), 127–141.
- Figley, C., & Figley, K. (2009). Stemming the tide of trauma systemically: The role of family therapy. *The Australian and New Zealand Journal of Family Therapy*, 30(3), 173–183.
- Galea, S., Nandi, A., & Vlahov, D. (2005). The epidemiology of Post-Traumatic Stress Disorder after disasters. *Epidemiologic Reviews*, 27(1), 78–91. Retrieved from www.ncbi.nlm.nih.gov
- Goldfinch, M. (2009). ‘Putting Humpty Together Again’: Working with parents to help children who have experienced early trauma. *The Australian and New Zealand Journal of Family Therapy*, 30(4), 284–299. doi:10.1375/anft.30.4.284
- Greenman, P., & Johnson, S. (2012). United we stand: Emotionally Focused Therapy for couples in the treatment of posttraumatic stress disorder. *Journal of Clinical psychology: In Session*, 68(2), 561–569.
- Greenwald, R. (2005). *Child Trauma Handbook*. Birmingham, NY: Hayworth Press.
- Greenwald, R. (2007). *EMDR Within a Phase Model of Trauma-Informed Treatment*. New York, N.Y.: Hayworth Press.
- Herman, J. (1992). *Trauma and Recovery*. London: Basic Books.
- Herman, J. (2002). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5(3), 377–391.
- James, K., & MacKinnon, L. (2010). The tip of the iceberg: A framework for identifying non-physical abuse in couple and family relationships. *Journal of Feminist Family Therapy*, 22(2), 112–129. doi:10.1080/08952831003787867
- James, K., & MacKinnon, L. (2011). Establishing the parental hierarchy: An integration of Milan systemic and structural family therapy. In A. Rhodes (Ed.), *A Practical Guide to Family Therapy* (pp. 59–75). Melbourne, Victoria: IP Communications.
- Johnson, S. (1998). Creating healing relationships for couples dealing with trauma: The use of emotionally focused marital therapy. *Journal of Marital and Family Therapy*, 24(1), 25–40. Retrieved from www.ncbi.nlm.nih.gov
- Johnson, S. (2002). *Emotionally Focused Couple Therapy with Trauma Survivors*. New York, N.Y.: Guilford Press.
- Lance, J., & Gyamera, J. (2002). Existential family trauma therapy. *Contemporary Family Therapy*, 24(2), 243–255.
- Lance, J., & Raiz, L. (2003). Play and art in existential trauma therapy with children and their parents. *Contemporary Family Therapy*, 25(2), 165–177. doi:10.1023/A:1023668000249
- Lander, I. (2011). Child-in-family therapy to heal a traumatically bereaved 10 year-old boy in grandparental kinship care: A case study. *Journal of Family Psychotherapy*, 22(4), 275–296.

- Lanktree, C. (2008). *Integrative treatment of complex trauma for children (ITCT-C): A guide for the treatment of multiply-traumatized children aged eight to twelve years* (pp. 1–124). National Child Traumatic Stress Network (NCTSN).
- MacIntosh, H., & Johnson, S. (2008). Emotionally focused therapy for couples and childhood sexual abuse survivors. *Journal of Marital and Family Therapy*, 34(3), 298–315.
- MacKinnon, L. (2008). Hurting without hitting: Verbal, emotional and psychological abuse. *Australian Domestic and Family Violence Clearinghouse, Stakeholder*.
- MacKinnon, L. (1998). *Trust and Betrayal in the Treatment of Child Abuse*. New York, N.Y.: Guilford Press.
- McCann, I., & Pearlman, L. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3(1), 131–149.
- McCullough, L. (2002). Exploring change mechanisms in EMDR applied to ‘small-t trauma’ in short-term dynamic psychotherapy: Research questions and speculations. *Journal of Clinical Psychology*, 58(12), 1531–1544.
- McGoldrick, M., Gerson, R., & Petry, S. (2008). *Genograms: Assessment and Intervention*. New York, N.Y.: W.W. Norton & Co.
- Perry, B. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatized children. In N. Boyd-Webb (Ed.), *Traumatized Youth in Child Welfare* (pp. 27–52). New York, N.Y.: Guilford Press.
- Perry, B. (2009). Examining child maltreatment through a neurobiological lens: Clinical applications of the Neurosequential Model of Therapeutics. *Journal of Loss and Trauma*, 14, 240–255.
- Riggs, D. (2000). Marital and family therapy. In E. Foa, T. Keane, & M. Friedman (Eds.), *Effective Treatments for PTSD*. New York, N.Y.: Guilford Press.
- Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: implications for the mental health of health workers? *Clinical Psychology Review*, 23(3), 449–480. Retrieved from [linkinghub.elsevier.com](http://linkinghub.elsevier.com)
- Schore, A., & McIntosh, J. (2011). Family law and the neuroscience of attachment, part 1. *Family Court Review*, 49(3), 501–512.
- Shapiro, F. (2001). *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures*. New York, N.Y.: Guilford Press.
- Shapiro, F., Kaslow, F., & Maxfield, L. (2007). *Handbook of EMDR and Family Therapy Processes*. New Jersey: John Wiley & Sons.
- Todd, B. (2007). Assisting the traumatised: Vicarious traumatization and the preservation of meaning. *Psychotherapy in Australia*, 13(3), 44–49.
- Van der Kolk, B., McFarlane, A., & Weisaeth, L. (1996). Traumatic stress: The effects of overwhelming experience on mind, body, and society. In B. Van der Kolk, A. McFarlane, & L. Weisaeth (Eds.), *Body and Society* (p. 596). New York, N.Y.: Guilford Press.

### **Appendix 1: Measures for screening**

Child Trauma Measures for Research and Practice <http://www.childtrauma.com/mezpost.html>

The DASS measures the three related negative emotional states of depression, anxiety, and tension/stress. <http://www2.psy.unsw.edu.au/groups/dass/>

PCL-C PTSD Checklist. [http://www.mirecc.va.gov/docs/visn6/3\\_PTSD\\_CheckList\\_and\\_Scoring.pdf](http://www.mirecc.va.gov/docs/visn6/3_PTSD_CheckList_and_Scoring.pdf)

Impact of Event Scale - Revised (IES-R) <http://www.ptsd.va.gov/professional/pages/assessments/ies-r.asp> [www.serene.me.uk/tests/ies-r.pdf](http://www.serene.me.uk/tests/ies-r.pdf)

The Dissociative Experiences Scale (DES) [http://en.wikipedia.org/wiki/Dissociative\\_Experiences\\_Scale](http://en.wikipedia.org/wiki/Dissociative_Experiences_Scale) [www.serene.me.uk/tests/des.pdf](http://www.serene.me.uk/tests/des.pdf)